



COMMUNITY PSYCH REHAB PROGRAM MANUAL

Table of Contents

Section 1: Reimbursement Methodology	8
1.1 The Basis for Establishing a Rate of Payment	8
1.2 Community Psychiatric Rehabilitation Services Reimbursement	9
1.3 Fee Schedule	9
Section 2: Benefits and Limitations	9
2.1 Authorization	9
2.2 Provider Participation	9
2.3 Adequate Documentation	10
2.4 Participant Eligibility	11
2.5 Qualified Providers of Community Psychiatric Rehabilitation Services	12
Advanced Practice Registered Nurse	12
Assistant Physician	12
Certified Peer Specialist	12
Community Support Specialist	12
Community Support Supervisor	13
Certified Family Support Provider	14
Group Rehabilitation Support Specialist	14
Licensed Mental Health Professional (for Diagnosis)	14
Licensed Practical Nurse	14
Licensed Marital and Family Therapist	15
Physician	15
Physician Assistant	15
Psychiatric Pharmacist	15
Resident Physician	15
Psychiatrist	15
Psychologist	15
Qualified Addiction Professional	15
Qualified Mental Health Professional	16
Registered Nurse	16

Rehabilitation Assistant	16
2.6 Definitions	17
Community Psychiatric Rehabilitation Provider Requirements	17
Collateral Contact	18
Physician/Physician Extender	18
Serious Mental Illness or Serious Emotional Disturbance	18
2.7 General Limitations	19
2.8 Admission to Community Psychiatric Rehabilitation	20
Diagnosis	20
Disability	20
Duration.....	21
2.9 Delivery of Community Psychiatric Rehabilitation Services.....	21
Intake Evaluation.....	21
Eligibility Requirements When Using a Functional Assessment.....	21
Provisional Admission for Children and Youth.....	22
Enrollment.....	23
2.10 Covered Services	23
2.10.A Modifiers.....	23
2.10.B Intake Evaluation	24
Eligibility Determination	24
Comprehensive Assessment	24
Treatment Planning	26
Initial Treatment Plan	26
Periodic Treatment Plan Reviews/Updates	27
Annual Treatment Plan	27
Functional Assessment.....	28
Annual Evaluation/Assessment	28
Limitations for Evaluations and Treatment Plans	28
Documentation Requirements for Evaluations and Treatment Planning	28
2.10.C Behavioral Health Assessment.....	29
Limitations for Behavioral Health Assessment	30
2.10.D Crisis Prevention and Intervention	30

Limitations for Crisis Prevention and Intervention.....	30
Documentation Requirements for Crisis Prevention and Intervention	30
2.10.E Medication Services	31
Limitations for Medication Services	32
Documentation Requirements for Medication Services	32
2.10.F Medication Administration	32
Limitations for Medication Administration	32
Documentation Requirements for Medication Administration	33
2.10.G Metabolic Syndrome Screening.....	33
Limitations for Metabolic Syndrome Screening	33
Documentation Requirements for Metabolic Syndrome Screening.....	33
2.10.H Community Support	33
Limitations for Community Support	35
Documentation Requirements for Community Support.....	35
2.10.I Intensive Community Psychiatric Rehabilitation	35
Documentation Requirements for Intensive Community Psychiatric Rehabilitation Services	37
Intensive Community Psychiatric Rehabilitation for Children and Youth.....	37
Intensive Community Psychiatric Rehabilitation for Adults in Non-Residential Settings	38
Limitations for Adults in Non-Residential Settings.....	39
Documentation Requirements for Adults in Non-Residential Settings	39
Intensive Community Psychiatric Rehabilitation for Transition Age Youth (Ages 16-25) in Non-Residential Settings	39
Limitations for Transition Age Youth in Non-Residential Settings	39
Documentation for Transition Age Youth in Non-Residential Settings.....	40
Intensive Community Psychiatric Rehabilitation for Evidence-Based Practices For Youth....	40
Limitations for Evidence-Based Practices for Youth.....	40
Documentation Requirements for Evidence-Based Practices for Youth	40
Intensive Community Psychiatric Rehabilitation for Children/Youth in Residential Settings – Treatment Family Home-Based Services.....	40
Limitations for Children/Youth in Residential Settings – Treatment Family Home-Based Services.....	41

Documentation Requirements for Children/Youth in Residential Settings – Treatment Family Home-Based Services	41
Intensive Community Psychiatric Rehabilitation for Children/Youth in Residential Settings – Professional Parent Home-Based Services.....	42
Limitations for Children/Youth in Residential Settings – Professional Parent Home-Based Services	43
Documentation Requirements for Children/Youth in Residential Settings – Professional Parent Home-Based Services	43
Intensive Community Psychiatric Rehabilitation for Children’s Inpatient Diversion	43
Limitations for Children’s Inpatient Diversion	44
Documentation Requirements for Children’s Inpatient Diversion.....	44
Intensive Community Psychiatric Rehabilitation – for Adult Inpatient Diversion.....	44
Limitations for Adult Inpatient Diversion.....	44
Documentation Requirements for Adult Inpatient Diversion	44
Intensive Community Psychiatric Rehabilitation for Residential—Clustered Apartments	45
Limitations for Residential—Clustered Apartments.....	45
Documentation Requirements for Residential – Clustered Apartments	45
Intensive Community Psychiatric Rehabilitation for Intensive Residential Treatment Setting	46
Limitations for Intensive Residential Treatment Setting	47
Documentation Requirements for Intensive Residential Treatment Setting	47
Intensive Community Psychiatric Rehabilitation for Psychiatric Individualized Supported Living	47
Limitations for Psychiatric Individualized Supported Living	48
Documentation Requirements for Psychiatric Individualized Supported Living.....	48
2.10.J Peer Support	48
Limitations for Peer Support	50
Documentation Requirements for Peer Support.....	50
2.10.K Psychosocial Rehabilitation.....	50
Documentation Requirements for Psychosocial Rehabilitation Services.....	51
Psychosocial Rehabilitation for Adults.....	51
Psychosocial Rehabilitation for Children and Youth	52

Limitations for Psychosocial Rehabilitation	53
Documentation Requirements for Psychosocial Rehabilitation.....	53
Psychosocial Rehabilitation Illness Management and Recovery	53
Limitations for Psychosocial Rehabilitation Illness Management and Recovery	53
Documentation Requirements for Psychosocial Rehabilitation Illness Management and Recovery.....	54
2.10.L Individual Professional Psychosocial Rehabilitation and Group Professional Psychosocial Rehabilitation	54
Limitations for Individual Professional Psychosocial Rehabilitation and Group Professional Psychosocial Rehabilitation	54
Documentation Requirements for Individual Professional Psychosocial Rehabilitation and Group Professional Psychosocial Rehabilitation.....	54
2.10.M Physician Consultation/Professional Consultation	54
Limitations for Physician and Professional Consultation.....	55
Documentation Requirements for Physician and Professional Consultation	55
2.10.N Integrated Treatment for Co-Occurring Disorders	55
Co-Occurring Assessment Supplement	57
Limitations for the Co-Occurring Assessment Supplement.....	57
Documentation Requirements for the Co-Occurring Assessment Supplement	57
Co-Occurring Individual Counseling.....	58
Limitations for Co-Occurring Individual Counseling	58
Documentation Requirements for Co-Occurring Individual Counseling	58
Co-Occurring Group Counseling	58
Limitations for Co-Occurring Group Counseling	58
Documentation Requirements for Co-Occurring Group Counseling.....	59
Co-Occurring Group Rehabilitative Support.....	59
Limitations for Co-Occurring Group Rehabilitative Support	59
Documentation Requirements for Co-Occurring Group Rehabilitative Support.....	59
2.10.O Day Treatment for Children/Youth.....	60
Limitations for Day Treatment for Children/Youth	61
Documentation Requirements for Day Treatment for Children/Youth	61
2.10.P Family Support	62

Limitations for Family Support	63
Documentation Requirements for Family Support.....	63
2.10.Q Family Assistance.....	63
Limitations for Family Assistance	63
Documentation Requirements for Family Assistance	63
2.10.R Assertive Community Treatment.....	64
Limitations for Assertive Community Treatment	69
Documentation Requirements for Assertive Community Treatment.....	70
2.10.S Act Group Psychosocial Rehabilitation Services	70
Limitations for Act Group Psychosocial Rehabilitation Services.....	70
Documentation Requirements for Act Group Psychosocial Rehabilitation Services	70
2.10.T Act Group Psychotherapy	71
Limitations for Act Group Psychotherapy	71
Documentation Requirements for Act Group Psychotherapy.....	71
2.10.U School-Based Services	71
Documentation Requirements for School-Based Services	71
2.11 Laboratory Services	72
2.12 Prescription Drugs	72
2.13 Administrative Lock-In	72
2.14 Quality Assurance	72
Section 3: Billing Instructions	72
3.1 Claim Submission	72
3.2 Resubmission of Claims.....	73
3.3 Inquiries	73
3.4 Community Psychiatric Rehabilitation Invoices	73
3.5 Payments.....	73
3.6 Insurance Coverage Codes.....	73
3.7 Community Psychiatric Rehabilitation Rebill Instructions	74
3.8 Special Billing Issues.....	74
Section 4: Diagnosis Codes	74
4.1 General Information	74
4.2 ICD-Clinical Modification Diagnosis Chart.....	74

Section 5: Procedure Codes	78
5.1 Procedure Codes	79
5.2 Place of Service	87

Introduction

Community Psychiatric Rehabilitation (CPR) services are targeted to individuals with a serious mental illness (SMI) or serious emotional disturbance (SED), as defined in this manual, who meet diagnostic criteria for admission to CPR and are eligible for MO HealthNet benefits. Services include assessment, treatment and community support services furnished by or under the direction of a physician/physician extender. Reimbursement is limited to qualified CPR providers enrolled in the MO HealthNet Program. CPR provides community-based services designed to maximize independent functioning and promote community adjustment and integration.

Section 1: Reimbursement Methodology

1.1 The Basis for Establishing a Rate of Payment

The MO HealthNet Division (MHD) establishes and administers the payment rates for medical services covered by the Missouri Title XIX Program. MHD sets a payment rate to meet the following goals:

- Ensures access to quality medical care for all participants by encouraging an adequate number of providers
- Allows for no adverse impact on private-pay participants
- Assures a reasonable rate to protect the interests of the taxpayers
- Provides incentives that encourage efficiency on the part of medical providers

Funds used to reimburse providers for services rendered to eligible participants are received, in part, from federal funds and supplemented by state funds to cover costs. The funding amount from the federal government is based on a percentage of allowable expenditures. The percentage varies from program to program, and some services within the same program may have different percentages. Funding from the federal government ranges from 60% to 90%, depending on the service or program. State general revenue appropriated funds make up the balance of allowable expenditures, from 10% to 40%.

Under the **Fee Schedule** each procedure, service, medical supply and equipment covered under a specific program has a maximum allowable rate established. In determining what this rate should be, MHD considers the following information when applicable:

- Recommendations from the State Medical Consultant and/or the provider subcommittee of the Medical Advisory Committee and/or stakeholders
- Medicare's allowable reasonable and customary charge payment or cost-related payment, if applicable
- Charge information obtained from providers in different areas of the state. Charges refer to the usual and customary fees for various services that are charged to the general public

MHD then determines a maximum allowable rate for the service based upon all applicable information and current appropriated funds.

Total expenditures for MHD must be within the appropriation limits established by the General Assembly. If the expenditures exceed the appropriation limits and funds are insufficient to pay the total amount, payment for services may be reduced pro rata in proportion to the deficiency.

1.2 Community Psychiatric Rehabilitation Services Reimbursement

Reimbursement for Community Psychiatric Rehabilitation (CPR) services is made on a fee-for-service basis. The maximum allowable fee for a unit of service has been determined by MHD to be a reasonable fee, consistent with efficiency, economy, and quality of care. Payment for covered services is the lower of the provider's actual billed charge (should be the provider's usual and customary charge to the general public for the service), or the maximum allowable per unit of service.

1.3 Fee Schedule

The [Fee Schedule](#) identifies covered and non-covered procedure codes, restrictions, allowed units, and MHD allowable fee per unit. The online Fee Schedule is updated monthly and is intended as a reference, not a guarantee for payment.

The [Fee Schedule](#) can be searched for a specific procedure code or it can be downloaded. Some procedure codes may be billed by multiple provider types. Categories within the Fee Schedule are set up by the service rendered, and are not necessarily provider specific.

Section 2: Benefits and Limitations

2.1 Authorization

[Chapter 208.152, RSMo](#) authorizes coverage of CPR services when such services are provided by administrative agents and affiliates that qualify as CPR providers in accordance with [9 CSR 30-4.005](#) through [30-4.047](#) and [9 CSR 10-7.010](#) through [10-7.140](#).

2.2 Provider Participation

The Department of Mental Health (DMH), through an interagency agreement with the Department of Social Services (DSS), Missouri Medicaid Audit and Compliance (MMAC) Unit, reviews all requests for participation in the CPR Program and provides validation of the applicant's certification status to MMAC. MMAC, based upon review of the application and certification by DMH, approves or denies the application request.

To participate in the MO HealthNet Program CPR Program, the organization must satisfy the following requirements:

- Be certified as a CPR provider by DMH in accordance with [9 CSR 30-4.005](#) through [30-4.047](#) and [9 CSR 10-7.010](#) through [10-7.140](#), and submit a copy of their current DMH certification with the enrollment forms. In order to receive federal funds and participate in the MO HealthNet Program, all providers must comply with all applicable state and federal laws including, but not limited to, civil rights laws and regulations regarding service

delivery. It is the provider's responsibility to review the [civil rights information](#) available through DSS.

- Complete necessary provider enrollment documents and agreements required by the MMAC Unit. These documents can be requested by emailing MMAC Provider Enrollment at MMAC.ProviderEnrollment@dss.mo.gov.
- Agree to maintain for six (6) years, or longer if specified by a contract with DMH, auditable program records reflecting services provided, individuals' progress in treatment, number of individuals served and related demographic information , and other relevant program records.
- Allow DSS or its authorized representative (MMAC, DMH, etc.) to inspect and examine its premises and records that relate to the provision of services under this program.
- Employ and retain qualified/licensed mental health professionals to render the services covered through the MHD CPR Program or any additional state or federal regulations.

Refer to the [General Sections Manual](#) for further information regarding provider participation.

2.3 Adequate Documentation

All services provided must be adequately documented in the medical/clinical record. Documents retained by CPR providers must include the treatment plan and the clinical records. Information must be sufficient to disclose the actual provider of the service, quantity, quality, appropriateness and timelines of services provided under the agreement.

Time spent documenting service interventions, when it is done collaboratively with the participant during the course of the service activity/intervention, is considered billable time. Collaborative documentation occurs when the individual is engaged with the service provider/practitioner and this process is integrated into the service session. It is done collaboratively with the individual and involves sharing the assessment, treatment plan, or documentation with the individual as it is being written by the service provider to assure a consistent understanding as to what was accomplished during the service session.

Collaborative documentation is not typing or writing notes throughout a treatment session or taking time at the end of a session to write a note in front of an individual who is waiting to leave and who is uninvolved. The individual must be actively involved and engaged in writing the note, including seeing and contributing to the note. Providers utilizing collaborative documentation must have policies and procedures in place addressing its use.

Documentation required for CPR MHD reimbursement of each CPR session, service or activity, shall consist of the following:

- First name, last name and either middle initial or date of birth of the MO HealthNet participant
- Accurate, complete and legible description of each service(s) provided
- Name, title, and signature of the MO HealthNet enrolled provider delivering the service. Services provided by an individual under the direction or supervision of a MO HealthNet

provider and/or services provided by a person not enrolled with MHD are not reimbursed by MHD.

- Name of the referring entity, when applicable
- Date of service (month/day/year)
- Actual begin and end time taken to deliver the service for those MO HealthNet programs and services that are reimbursed according to the amount of time spent in delivering or rendering a service(s) (for example, 4:00 p.m. - 4:30 p.m.) When billing Medication Services using Current Procedural Terminology (CPT) Evaluation/Management (E/M) procedure codes, clock time is not required unless the provider spends over 50% of the time on counseling and/or care coordination and uses the actual clock time as the key factor to determine which E/M code to bill.
- Setting in which the service was rendered.
- Plan of treatment, evaluation(s), test(s), findings, results, and prescription(s), as necessary
- Need for the service(s) in relationship to the MO HealthNet participant's treatment plan
- MO HealthNet participant's progress toward the goals stated in the treatment plan (progress notes).
- For applicable programs, it is necessary to have adequate invoices, trip tickets/reports, activity log sheets, employee records (excluding health records) and training records of staff.

The requirements listed above represent minimal elements for maintaining adequate documentation required by MHD. Additional documentation may be needed to satisfy the requirements of outside reviews or delivery of a specific CPR service. If additional documentation is required for a specific service, it will be included with the service description in this manual.

For additional information relating to adequate documentation, please reference the General Sections Manual.

2.4 Participant Eligibility

To participate in CPR Services, the individual must have MO HealthNet coverage for each date a service is rendered in order for reimbursement to be made to a provider.

The state only funded Medical Eligibility (ME) codes not eligible to receive CPR benefits are as follows:

ME Code	Description	ME Code	Description
02	Blind Pension	64	Group Home – Health Initiative Fund (State Placement)
08	Child Welfare Services-Foster Care	65	Group Home – Health Initiative Fund – (Parent/Guardian Placement)
52	Division of Youth Services – General Revenue	82	Missouri Rx (Medicare Part D wrap-around benefits)

57	Child Welfare Services – Foster Care – Adoption Subsidy	0F	Foster Care – IMD Placement
59	Presumptive Eligibility (Non-Subsidized)	5A	Adoption Sub-Guardianship IMD Placement

The ME codes with restricted benefit packages not eligible to receive CPR benefits are as follows:

ME Code	Description	ME Code	Description
55	Qualified Medicare Beneficiary (QMB)	82	Missouri Rx (Medicare Part D wrap-around benefits)
58	Presumptive Eligibility (Subsidized)	89	Uninsured Women’s Health Services
59	Presumptive Eligibility (Non-Subsidized)	94	Show-Me Healthy Babies – Presumptive Eligibility Income to 300%
80	Extended Women’s Health Services		

2.5 Qualified Providers of Community Psychiatric Rehabilitation Services

The following are qualified providers of CPR Services and a description of each.

Advanced Practice Registered Nurse

An Advanced Practice Registered Nurse (APRN) is a licensed registered nurse (RN) certified by a nationally recognized professional organization as a certified nurse practitioner, certified nurse midwife, certified nurse anesthetist or certified clinical nurse specialist under Missouri law. When providing medication administration or medication services, an APRN must be in a collaborating practice arrangement with a licensed physician.

Assistant Physician

An Assistant Physician is a person licensed under Missouri law who performs tasks that might otherwise be performed by a licensed physician. Assistant physicians must have a collaborating practice arrangement with a physician licensed in Missouri.

Certified Peer Specialist

A Certified Peer Specialist is an individual in recovery from mental illness and/or a substance use disorder (SUD) who has at least a high school diploma or equivalent and is credentialed by the Missouri Credentialing Board (MCB.)

A Certified Peer Specialist must be supervised by a qualified addiction professional (QAP) or qualified mental health professional (QMHP).

Community Support Specialist

A Community Support Specialist (CSS) is an individual meeting one (1) of the following qualifications:

- A QMHP as defined in this manual
- A QAP as defined in this manual
- An individual with a bachelor's degree in a human services field including, but not limited to social work, psychology, nursing, education, criminal justice, recreational therapy, human development and family science, counseling, child development, gerontology, sociology, human services, behavioral science and rehabilitation counseling
- An individual with any four (4) year degree and two (2) years of qualifying experience
- An individual with any four (4) year combination of higher education and qualifying experience
- An individual with four (4) years of qualifying experience
- An individual with an Associate of Applied Science in Behavioral Health Support degree from an approved institution

Qualifying experience must include delivery of services to individuals with mental illness, SUD, or intellectual and/or developmental disabilities (IDD). Experience must include at least one (1) of the following:

- Providing one-on-one or group services with a rehabilitation/habilitation and recovery/resiliency focus
- Teaching and modeling for individuals how to cope and manage psychiatric, developmental or SUD issues while encouraging the use of natural resources
- Supporting individuals in their efforts to find and maintain housing, employment and/or to function appropriately in families, school and communities
- Assisting individuals to achieve the goals and objectives on their individual treatment plans

CSSs must complete the necessary orientation and training requirements specified by DMH) and must be supervised by one (1) of the following:

- QMHP
- QAP
- Staff possessing a Master's degree in a behavioral health or related field who has completed a practicum or has one (1) year of experience in a behavioral health field
- Staff meeting the qualifications of a CSS with at least three (3) years of population-specific experience providing community support services in accordance with the key service functions specified in [Section 2.10.H](#) of this manual. It is the responsibility of the provider to clearly document how staff meet the qualifications listed above.

Community Support Supervisor

A Community Support Supervisor is an individual who meets one of the following:

- QAP
- QMHP
- Meets the qualifications of a CSS with at least three (3) years of population-specific experience providing community support services in accordance with the key service functions specified in [Section 2.10.H](#) of this manual.

Community support supervisors who are not a QAP or QMHP must be supervised by a QAP or QMHP.

Certified Family Support Provider

A Certified Family Support Provider is a family member of a child/youth who had or currently has a behavioral/emotional disorder or a SUD; has a high school diploma or equivalent certificate; is credentialed by the MCB and is supervised by a QMHP or QAP.

Group Rehabilitation Support Specialist

A Group Rehabilitation Support Specialist is an individual who:

- Is suited by education, knowledge, background or experience to present the information being discussed
- Demonstrates competency and skill in facilitating group discussion

Group rehabilitation support specialists must be supervised by a QAP or a QMHP.

Licensed Mental Health Professional (for Diagnosis)

The following mental health professionals are approved to render diagnoses:

- A physician (including psychiatrist) licensed under Missouri law to practice medicine or osteopathy
- A psychologist licensed or provisionally licensed under Missouri law to practice psychology
- Resident physician (including resident psychiatrist)
- A professional counselor licensed or provisionally licensed under Missouri law to practice counseling
- A clinical social worker licensed under Missouri law to practice social work
- A master social worker (LMSW) under registered supervision with the Missouri Division of Professional Registration for licensure as a Clinical Social Worker (LCSW.) LMSWs not under registered supervision for their LCSW credential cannot render a diagnosis.
- A marital and family therapist licensed or provisionally licensed under Missouri law to provide marriage and family services
- APRN
- Assistant physician, a licensed assistant physician under Missouri law
- Physician assistant, a licensed physician assistant under Missouri law

These professions are categorically approved as licensed diagnosticians as long as the diagnostic activities performed fall within the scopes of practice for each. However, individuals possessing these credentials should practice in the areas in which they are adequately trained and should not practice beyond their individual levels of competence.

Licensed Practical Nurse

A Licensed Practical Nurse (LPN) is a person licensed as a practical nurse under Missouri law to furnish services within their scope of practice.

Licensed Marital and Family Therapist

A Licensed Marital and Family Therapist is a person licensed under Missouri law to furnish services within their scope of practice.

Physician

A physician is an individual licensed under Missouri law to furnish services within their scope of practice.

Physician Assistant

A Physician Assistant is a person who has graduated from a physician assistant program accredited by the American Medical Association's Committee on Allied Health Education and Accreditation or by its successor agency, has passed the certifying examination administered by the National Commission on Certification of Physician Assistants and has active certification by the National Commission on Certification of Physician Assistants who provides health care services delegated by a licensed physician under Missouri law.

Psychiatric Pharmacist

A Psychiatric Pharmacist is a registered pharmacist in good standing with the Missouri Board of Pharmacy who is a board-certified psychiatric pharmacist (BCPP) through the Board of Pharmaceutical Specialties, or a registered pharmacist currently in a psychopharmacology residency where the service has been supervised by a BCPP.

Resident Physician

A Resident Physician is a medical school graduate and doctor in training who is taking part in a graduate medical education (GME) program.

Psychiatrist

A Psychiatrist is a licensed physician who delivers services within their scope of practice.

Psychologist

A Psychologist is an individual licensed under Missouri law to furnish services within their scope of practice.

Qualified Addiction Professional

A Qualified Addiction Professional is an individual who is one (1) of the following:

- A licensed or provisionally licensed physician
- An individual who meets the applicable training and credentialing required by the MCB for any of the following:
 - Certified Alcohol and Drug Counselor (CADC)
 - Certified Reciprocal Alcohol and Drug Counselor (CRADC)
 - Certified Reciprocal Advanced Alcohol and Drug Counselor (CRAADC)

- Certified Criminal Justice Addictions Professional (CCJP)
- Registered Alcohol Drug Counselor-Provisional (RADC-P)
- Registered Alcohol Drug Counselor (RADC)
- Co-Occurring Disorders Professional (CCDP)
- Co-Occurring Disorders Professional-Diplomat (CCDP-D)

Qualified Mental Health Professional

A QMHP, for the purpose of administration of the MHD CPR program, is defined as:

- An individual licensed or provisionally licensed as a physician under Missouri law to furnish services within their scope of practice.
- An individual licensed or provisionally licensed as a psychologist under Missouri law to furnish services within their scope of practice.
- A resident physician/resident psychiatrist
- A professional counselor licensed or provisionally licensed under Missouri law to practice counseling.
- A clinical social worker with a master's degree in social work from an accredited program and with specialized training in mental health services
- An individual possessing a master's degree in counseling and guidance, rehabilitation counseling and guidance, rehabilitation counseling, vocational counseling, psychology, pastoral counseling, social work or family therapy or related field who has successfully completed a practicum or has one (1) year of experience under the supervision of a mental health professional
- An occupational therapist certified by the National Board for Certification in Occupational Therapy registered in Missouri, has a bachelor's degree and has completed a practicum in a psychiatric setting or has one (1) year of experience in a psychiatric setting, or has a master's degree and has completed either a practicum in a psychiatric setting or has one (1) year of experience in a psychiatric setting
- A licensed assistant physician under Missouri state law
- A licensed physician assistant under Missouri state law.
- An APRN
- A psychiatric pharmacist who is a registered pharmacist in good standing with the Missouri Board of Pharmacy, is a BCPP through the Board of Pharmaceutical Specialties or a registered pharmacist currently in a psychopharmacology residency where the service has been supervised by a board-certified psychiatric pharmacist.

Registered Nurse

A Registered Nurse is an individual licensed under Missouri law to furnish services within their scope of practice.

Rehabilitation Assistant

A Rehabilitation Assistant is an individual with a high school diploma or equivalent certificate who provides services under the direction and supervision of a QMHP.

2.6 Definitions

The following provides definitions for terms used throughout this manual.

Community Psychiatric Rehabilitation Provider Requirements

A provider of CPR services that is certified or deemed certified by DMH as set forth in [9 CSR 30-4.005](#) through [30-4.047](#) and [9 CSR 10-7.010](#) through [10-7.140](#). Certification is contingent upon the provision of the core services listed below. These services may be provided directly by the CPR program or through a subcontract as specified in [9 CSR 10-7.090\(6\)](#).

At a minimum, CPR programs shall directly provide the following core services, or ensure the services are available through a subcontract as specified in [9 CSR 10-7.090\(6\)](#):

- Intake evaluation including:
 - Comprehensive assessment; Eligibility determination may be conducted to expedite the admission process, if necessary. Eligibility determination must be signed off by a licensed mental health professional or a physician/physician extender.
 - Functional assessment, as warranted by diagnosis or if required by the department
 - Treatment planning
 - Annual assessment
- Community support
- Crisis prevention and intervention
- Integrated Treatment for Co-Occurring Disorders (ITCD)
- Medication administration
- Medication services
- Metabolic syndrome screening (for children and adults receiving antipsychotic medications)
- Physician consultation/professional consultation
- Psychosocial Rehabilitation (PSR) for adults

Optional services include:

- Adult Inpatient Diversion
- Assertive Community Treatment (ACT)
- Behavioral Health Assessment/Brief Evaluation
- Children's Inpatient Diversion
- Co-Occurring Individual Counseling
- Co-Occurring Group Counseling
- Co-Occurring Group Rehabilitative Support
- Co-Occurring Assessment Supplement
- Day Treatment-Children/Youth
- Evidence Based Practices for Children/Youth

- Family Assistance
- Family Support
- Individual and Group Professional PSR
- Intensive CPR
- Metabolic syndrome screening (for children and adults) not receiving antipsychotic medications
- Peer Support
- Professional Parent Home-Based Services
- Psychosocial Rehabilitation Illness Management and Recovery (PSR-IMR)
- PSR for Youth
- Treatment Family Home-Based Services

Collateral Contact

Collateral contacts are a source of information regarding the individual's health, safety, functional needs or effectiveness of the individual's plan for services. Communication with a collateral contact may be made in person, audio only or by telemedicine.

Examples of collateral contacts that can be utilized to promote the recovery of an individual in services include, but are not limited to:

- Family members
- Therapeutic providers from other agencies providing services
- Pediatricians, family doctors, clinics, medical care specialists and other health care providers
- Pharmacy staff
- Legal agency affiliates (such as probation or parole officers)
- Education facilities
- Legal guardians

Physician/Physician Extender

A physician/physician extender is a specially licensed/certified and trained healthcare provider who performs tasks that might otherwise be performed by a licensed physician (includes psychiatrist) under the direction of a supervising licensed physician. Physician extender includes a licensed assistant physician, physician assistant, psychiatric resident, psychiatric pharmacist and APRN.

Serious Mental Illness or Serious Emotional Disturbance

Persons with a SMI or a SED experience mental disorders that interfere with functional/developmental capacities in relation to such primary aspects of daily life as self-care, interpersonal relationships and work or school. These disorders may often necessitate prolonged mental health care.

The following conditions are not included in the definition of SMI, unless accompanied by one (1) of the specific principal diagnoses of mental illness listed in [Section 4](#) of this manual:

- Neurodevelopmental disorder, or narcolepsy
- Simple intoxication caused by a SUD such as alcohol or drugs
- Dependence upon or addiction to any substance such as alcohol or drugs
- Any other disorders such as organic brain syndrome, which are not of an actively psychotic nature

The following condition is not included in the definition of SED:

- An exclusive diagnosis of Z code, conduct disorder, neurodevelopmental disorder (with the exception of attention-deficit/hyperactivity disorder) or SUD.

Conduct disorder is an eligible diagnosis if it is paired with a qualifying daily living assessment (DLA) score:

ICD10-CM CODE	DESCRIPTION	DSM-5 CODE	DESCRIPTION
F63.9	Impulse disorder, unspecified	F91.9	Unspecified disruptive, impulse-control, and conduct disorder
F91.8	Other conduct disorders	F91.8	Other specified disruptive, impulse-control, and conduct disorder
F63.81	Intermittent explosive disorder	F63.81	Intermittent explosive disorder
F91.9	Conduct disorder, unspecified	F91.9	Unspecified disruptive, impulse-control, and conduct disorder

2.7 General Limitations

The following general limitations apply to all MHD services provided through the CPR program:

- All services must be medically necessary*
- The service must be rendered by or under the direction of a physician/physician extender who participates in the development of and approves the treatment plan. A licensed psychologist may approve the treatment plan only when the individual is currently receiving no prescribed medications to treat a mental health condition(s) and the clinical recommendations do not include a need for prescribed medications for a mental health condition(s). A physician/physician extender may approve the treatment plan if they are providing medication services to the individual served.
- The service must be rendered by an appropriate and qualified individual or professional as defined in this manual and in [9 CSR 30-4.005](#) through [30-4.047](#) and [9 CSR 10-7.010](#) through [10-7.140](#)
- The service must be reasonable to the treatment of an individual's specific mental illness or disorder
- All other payers, (e.g. Medicare, Veterans Administration and third party insurance) must be billed prior to billing MHD, when applicable
- Services are not covered by MHD for persons who are receiving psychiatric inpatient hospital treatment. Services are covered on the day of admission and day of discharge.

- Certain CPR services are covered for persons who are receiving medical inpatient hospital treatment. Refer to [Section 5](#) of this manual for information on services covered.
- Services are not covered by MHD for individuals residing in a jail or detention facility. Services are covered on the day of admission to and day of discharge from those settings. In addition, services for youth in the custody of the Division of Youth Services (DYS) and are not placed in the highest level detention facility are covered by MHD.

*Medically necessary means health care services or supplies that are needed to diagnose or treat an illness, condition, disease, or its symptoms and that meet accepted standards of medicine.

2.8 Admission to Community Psychiatric Rehabilitation

The administrative agents and approved designees (affiliates) are authorized by DMH as entry and exit points into the state mental health service delivery system for a geographic service area defined by DMH in [9 CSR 30.4.005\(1\)\(A\)](#).

Diagnosis

Program eligibility includes individuals who are eligible for MO HealthNet coverage and have one (1) of the specific diagnoses listed in [Section 4](#) of this manual. A licensed mental health professional qualified to diagnose shall certify a primary diagnosis as defined in [Section 2.5](#) of this manual or International Classification of Diseases (ICD) using the current edition of the manual. This diagnosis may coexist with other psychiatric diagnoses. See [Section 4](#) for common ICD and Diagnostic and Statistical Manual of Mental Disorders (DSM-5-TR) diagnoses for CPR. Whenever discrepancies occur regarding the appropriateness of an ICD versus a DSM-5-TR diagnosis, the DSM-5-TR diagnosis shall prevail.

A functional assessment may be used to establish eligibility and the need for and amount of services, including results from a standardized assessment prescribed by DMH. Individuals identified for the [Disease Management \(DM\) 3700 project](#), and individuals enrolled in the [Behavioral Health Healthcare Home](#), are not required to have one of the specific diagnoses listed in [Section 4](#) of this manual.

Disability

There shall be clear evidence of serious and/or substantial impairment in the ability to function at an age or developmentally appropriate level due to serious psychiatric disorder in each of the following two (2) areas of behavioral functioning, as indicated by the intake evaluation and assessment.

- Social role functioning/family life—the ability to sustain functionally the role of a worker, student, homemaker, family member or a combination of these.
- Daily living skills/self-care skills—the ability to engage in personal care (such as grooming, personal hygiene) and community living (handling personal finances, using community resources, performing household chores), learning ability/self-direction and activities appropriate to the individual's age, developmental level and social role functioning.

Duration

Rehabilitation services shall be provided for individuals whose mental illness is of sufficient duration as evidenced by one (1) or more of the following:

- Received psychiatric treatment more intensive than outpatient more than once in a lifetime (crisis services, alternative home care, partial hospital, inpatient)
- Experienced an occurrence of continuous residential care other than hospitalization, for a period long enough to disrupt the normal living situation
- Exhibited the psychiatric disability for one (1) year or more
- Treatment of the psychiatric disorder has been or will be required for longer than six (6) months

2.9 Delivery of Community Psychiatric Rehabilitation Services

Intake Evaluation

An intake evaluation must be completed for each individual to determine eligibility for CPR services. This applies to any organized program or service(s) which an individual is admitted to and/or participates in for the purpose of receiving scheduled or planned mental health treatment that is to be reimbursed under MHD CPR.

The intake evaluation is the basis for determining the individual's program eligibility according to disability, diagnosis, duration and the need for mental health treatment. Details regarding the components of the intake evaluation are included in [Section 2.10.B](#) of this manual.

The written clinical record for each individual served must include a recommendation by a licensed mental health professional that CPR services are appropriate to meet the individual's specific treatment needs.

Eligibility Requirements When Using a Functional Assessment

A functional assessment shall be completed for individuals whose diagnosis requires a functional score to support admission.

Individuals age 26 and older may be determined eligible for CPR if they have a DSM-5-TR psychiatric diagnosis approved by DMH(see [Section 4](#) diagnoses chart), and an mGAF score of 40 or below.

Individuals age six (6) to 25 may be determined eligible for CPR if they have a serious emotional disturbance or DSM-5-TR psychiatric diagnosis approved by department policy (see [Section 4](#) diagnoses chart), and a CGAS score of 50 or below.

Individuals currently enrolled in youth CPR programs will be eligible for adult CPR, when transfer to an adult program is determined to be clinically appropriate, and they have a qualifying adult CPR diagnosis or adult DLA diagnosis.

For children age two (2) to five (5), the following functional assessment tools are approved by DMH.

- Devereaux Early Childhood Assessment Clinical Form (DECA-C); Total Behavior Concerns scale of 60 or higher
- Ages and Stages Social Emotional Screening tool; cutoff scores identified with the specific age ranges as identified in the manual are eligible for CPR
- Preschool and Early Childhood Functional Assessment Scale (PECFAS); total score of 90 or above

The initial, annual and discharge administrations of the functional assessment shall be completed by a QMHP. The administration of the functional assessment in conjunction with quarterly treatment plan updates may be completed by a CSS. Agencies utilizing the DLA20© must have received the appropriate training from the developer, medication therapy management (MTM) services. Following receipt of training, these individuals may train others within their agency on the administration of the instrument. Any staff person administering the DLA20© must be appropriately trained and documentation to support receipt of this training must be maintained by the agency.

The time spent completing the DLA20© or other functional assessment instrument must be clearly documented in a progress note and be easily distinguished from direct time spent providing other community support or clinical services, and must be filed in the individual's record.

Provisional Admission for Children and Youth

Under the following circumstances, children, youth and young adults under the age of 25 may be provisionally admitted to CPR:

- **Diagnosis:** If a person is exhibiting behaviors or symptoms consistent with a non-established CPR eligible diagnosis, they may be provisionally admitted to CPR for further evaluation. There may be insufficient clinical information because of rapidly changing developmental needs to determine if a CPR diagnosis is appropriate without an opportunity to observe and evaluate the person's behavior, mood and functional status. In such cases, there must be documentation that clearly supports the individual's level of functioning based on disability as defined in **9 CSR 30-4.005(7)(A)1.-2.**
- **Disability:** There is clear evidence of serious and/or substantial impairment in the ability to function at an age or developmentally appropriate level due to serious psychiatric disorder in each of the following two (2) areas of behavioral functioning as indicated by the intake evaluation and assessment:
 - Social role functioning/family life—the individual is at risk of out-of-home or out-of-school placement.
 - Daily living skills/self-care skills—the individual is unable to engage in personal care (such as grooming and personal hygiene) and in community living (performing school work or household chores), learning, self-direction or activities appropriate to the individual's age, developmental level and social role functioning.

- **Duration:** There must be documented evidence of an individual's functional disability as defined in [9 CSR 30-4.005\(7\)\(A\)1.-2.](#) for a period of 90 days prior to provisional admission.

Provisional admissions shall not exceed 90 days. Immediately upon completion of the 90 days, or sooner if the individual has been determined to have an eligible diagnosis as specified above. The diagnosis must be documented and the individual may continue to receive services in the CPR program.

If an individual who was provisionally admitted is determined to be ineligible for CPR services, staff shall directly assist the individual and/or family in arranging appropriate follow-up services needed. Arrangements for follow-up services shall be documented in the discharge summary of the clinical record.

All admission documentation is required for those provisionally admitted with the exception of the intake evaluation and assessment which may be deferred for 90 days.

Enrollment

To be eligible for reimbursement of services, the provider must enroll the individual for CPR services by submitting required information to DMH Customer Information, Management and Outcomes Reporting System (CIMOR).

2.10 Covered Services

CPR services must be billed using the appropriate modifiers listed below. Refer to [Section 5](#) for a complete list of procedure codes and the corresponding modifiers.

2.10.A Modifiers

Modifier	Description
52	Reduced services
AF	Child Psychiatrist
AR	Physician Assistant
GC	Psychiatric Resident
GT	Telemedicine
HA	Child/adolescent program
HE	Psychiatric Pharmacist
HH	Mental health/substance use program
HK	Specialized mental health programs for high-risk populations
HO	Master's level
HQ	Group Setting
SA	APRN
TD	RN
TE	LPN
TF	Intermedicate level of care

TG	Complex/high tech level of care
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The following CPR services are covered for individuals eligible for MHD benefits when medically necessary and the diagnosis is related to mental illness.

2.10.B Intake Evaluation

A unit of service is one (1) complete intake evaluation which includes completion of the following required components and written documentation:

- Eligibility determination, may be completed to expedite the admission process
- Comprehensive assessment
- Initial treatment plan
- Treatment plan updates/reviews

Eligibility Determination

Eligibility determination may be completed to expedite the admission process and requires confirmation of an eligible diagnosis by a licensed mental health professional. Documentation of eligibility determination includes, at a minimum:

- Presenting problem and referral source
- Brief history of previous psychiatric/SUD treatment including type of admission
- Current medications
- Current mental health symptoms (must support diagnosis)
- Current substance use
- Current medical conditions
- Diagnoses, including mental disorders, medical conditions and notation for psychosocial and contextual factors
- Functional assessment for individuals whose diagnosis requires a functional score to support admission
- Identification of urgent needs (suicide, personal safety, risk to others)
- Initial treatment recommendations
- Initial treatment goals to meet immediate needs within the first forty-five (45) days of service
- Signature, date, title, and credentials of all service providers

Comprehensive Assessment

A comprehensive assessment must be completed within 30 days of eligibility determination or date of admission if eligibility determination was not completed. Documentation of the comprehensive assessment shall include, at a minimum:

- Basic information (demographics, age, language spoken)
- Presenting concerns from the perspective of the individual, including reason for referral/referral source (what occurred to cause them to seek services)
- Risk assessment (suicide, safety, risk to others)
- Trauma history (experienced and/or witnessed abuse, neglect, violence, sexual assault)

- Mental health treatment history
- Mental status
- Substance use treatment history and current use including alcohol, tobacco and/or other drugs; for children/youth, prenatal exposure to alcohol, tobacco or other substances
- Medication information, including current medications, medication allergies/adverse reactions, efficacy of current or previously used medications
- Physical health summary (health screen, current primary care, vision and dental, date of last exams, current medical concerns, body mass index, tobacco use status and exercise level; immunizations for children/youth and any medical concerns expressed by family members that may impact the child/youth)
- Functional assessment using an instrument approved by DMH for individuals whose diagnosis requires a functional score to support admission (challenges, problems in daily living, barriers)
- Risk-taking behaviors including child/youth risk behavior(s)
- Living situation, including where living and with whom, financial situation, guardianship, need for assistive technology and parental/guardian custodial status for children/youth
- Family, including cultural identity, current and past family life experiences, family functioning/dynamics, relationships, current issues/concerns impacting children/youth
- Developmental information, including an evaluation of current areas of functioning such as motor development, sensory, speech, hearing and language, emotional, behavioral, intellectual functioning and self-care abilities
- Spiritual beliefs/religious orientation
- Sexuality, including current sexual activity, safe sex practices and sexual orientation
- Need for and availability of social, community and natural supports/resources such as friends, pets, meaningful activities, leisure/recreational interests, self-help groups, resources from other agencies, interactions with peers including child/youth and family
- Legal involvement history
- Legal status such as guardianship, representative payee, conservatorship, probation/parole
- Education including intellectual functioning, literacy level, learning impairments, attendance, achievement
- Employment, including current work status, work history, interest in working and work skills
- Status as a current or former member of the U.S. Armed Forces
- Clinical formulation, an interpretive summary including identification of co-occurring or co-morbid disorders, psychological/social adjustment to disabilities and/or disorders
- Diagnosis
- Individual's expression of service preferences
- Assessed needs/treatment recommendations such as life goals, strengths, preferences, abilities, barriers
- Signature/date, title and credentials of staff completing the assessment

Consent to Treatment - Each individual served or a parent/guardian must provide informed, written consent to treatment. A copy of the consent form, which must include the date of consent and signature of the individual served or a parent/guardian, shall be retained and maintained in the individual's record. Consent to treat shall be updated annually.

Treatment Planning

Treatment planning is covered for the development of the individual's initial treatment plan and regular reviews and updates to the plan, including related documentation. An individual treatment plan is required for each individual enrolled in the CPR program and is developed collaboratively with the individual or parent/guardian and a QMHP, the individual's community support supervisor (if different from the QMHP), with finalization by a licensed mental health professional.

Initial Treatment Plan

An individual treatment plan must be developed within 45 days of the date of admission with completion of the comprehensive assessment or eligibility determination with requirements met, and should be completed sooner if clinically indicated.

A physician/physician extender's signature/date must be obtained within 90 days of completion of eligibility determination or the comprehensive assessment after a consultation or case review. The physician/physician extender signature certifies treatment is needed and services are appropriate, as described in the treatment plan, and does not recertify the diagnosis.

A licensed psychologist may approve the treatment plan only in instances when the individual is not currently receiving prescribed medications to treat a mental health condition(s) and the clinical recommendations do not include a need for prescribed medications to treat a mental health condition(s.)

For individuals 18 years of age and younger, the parent/guardian must participate in the development of the treatment plan.

Documentation for completion of the initial treatment plan must include, at a minimum:

- Identifying information
- Goals as expressed by the person served and family members/natural supports, as appropriate, that are measurable, achievable, time-specific with start date, strength/skill based and include supports/resources needed to meet goals and potential barriers to achieving goals
- Specific treatment objectives, including a start date, that are understandable to the individual served, sufficiently specific to assess progress, responsive to the disability or concern and reflective of age, development, culture and ethnicity
- Specific interventions including action steps, modalities and services to be used, duration and frequency of interventions, who is responsible for the intervention, and action steps of the individual served and their family/natural supports

- Identification of other agencies/community resources and supports including others providing services, plans for coordinating with other agencies, services needed beyond the scope of the CPR program to be addressed through referral/services with another organization
- Anticipated discharge and continuing recovery planning which includes, but is not limited to, criteria for service conclusion, how will the individual served and/or parent/guardian and clinician know treatment goals have been accomplished
- Signature/date of the QMHP/community support supervisor

Periodic Treatment Plan Reviews/Updates

Treatment plans or the functional assessment, if utilized, must be updated at least quarterly, more frequently if clinically indicated. Documentation for the quarterly update must include, at a minimum:

- A progress note which specifies updates made to the treatment plan
- A treatment plan review conducted quarterly
- An updated functional assessment with narrative

Treatment plan reviews must be signed and dated by staff completing the review and the individual served unless there is a current signed consent to treatment in the individual record. For individuals receiving services in a community residential program, the treatment plan must be updated a minimum of every 90 days and documented in the individual record.

Annual Treatment Plan

Treatment plans must be updated annually to reflect current goals, needs and progress in treatment. The update must be completed between 30 days prior through 30 days after the anniversary date of the annual treatment plan. The annual treatment plan is updated collaboratively with the individual or parent/guardian and members of the treatment team.

Documentation for completion of the annual treatment plan must include, at a minimum:

- Updates related to the annual assessment and periodic updates to the functional assessment and/or quarterly treatment plan
- Signature/date of the community support supervisor
- Signature/date of the CSS
- Signature/date of the physician/physician extender

A licensed psychologist may take the place of the physician/physician extender and approve and date/sign the treatment plan when the individual is not currently receiving prescribed medications to treat a mental health condition(s), and the clinical recommendations do not include a need for prescribed medications to treat a mental health condition(s.) An APRN or psychiatric resident may approve (sign/date) the treatment plan if they are providing medication services to the individual.

If the physician/physician extender or licensed psychologist (if no medications are prescribed to treat a mental health condition) fails to sign the initial or annual treatment plan it will result in disallowance of the services billed.

Functional Assessment

A functional assessment must be completed with individuals whose diagnosis requires a functional score to support admission. Documentation of the findings from the functional assessment includes any of the following:

- A narrative section with the treatment plan that includes the functional update content requirements
- A narrative section on the functional assessment with the content requirements
- A progress note in the individual record documenting the content requirements

The initial functional assessment must be completed by a QMHP. Quarterly administration of the functional assessment update may be completed by a QMHP or by a CSS who has received appropriate training to complete a functional assessment.

When a CSS completes the functional assessment update and composes the additional required content, up to two (2) units of community support (H0036) may be billed. The units billed should reflect actual time spent and thus, billing time may vary by individual. When a QMHP completes the functional assessment, up to two (2) units of behavioral health assessment (H0002 and H0002 GT) may be billed. The units billed should reflect actual time spent and thus, billing time may vary by individual. Refer to [Section 2.10.C](#) for more information.

Annual Evaluation/Assessment

The unit of service is one (1) complete annual evaluation which includes completion of the required components and written documentation, including the annual assessment, treatment plan and functional update/treatment plan reviews. An annual assessment is required for all individuals receiving CPR services and includes the following components:

- Identification of sections of the clinical assessment being updated, such as check boxes
- Updated narrative for each section of the previous assessment that has changed
- Clinical formulation (interpretive summary)
- Diagnosis change/update
- Individual's expression of service preferences
- Assessed needs/treatment recommendations
- Signature/date of the QMHP completing the assessment, Community Support Supervisor, unless they are completing the assessment, and a licensed mental health professional

Limitations for Evaluations and Treatment Plans

Evaluation services are limited to one (1) initial intake or annual assessment/evaluation per individual, per provider during an 11 month period, beginning with the initial intake. The rate for the initial intake and the comprehensive annual evaluation includes the cost of treatment planning. Treatment planning is limited to 50 hours (200 units) annually per individual.

Documentation Requirements for Evaluations and Treatment Planning

All evaluations and treatment plans must be maintained in the individual's clinical record, including the below.

Procedure Code	Description
H0031	Comprehensive Intake Evaluation/Treatment Plan
H0031 GT	Comprehensive Intake Evaluation/Treatment Plan (Telehealth)
H0031 52	Comprehensive Annual Evaluation/Treatment Plan
H0031 52 GT	Comprehensive Annual Evaluation/Treatment Plan (Telehealth)
H0032	Treatment Planning
H0032 GT	Treatment Planning (Telehealth)

2.10.C Behavioral Health Assessment

The Behavioral Health Assessment service is separate from the assessment function in the bundled CPR Evaluation. The Behavioral Health Assessment consists of a comprehensive evaluation of an individual's physical, mental and emotional health, including issues related to substance use, along with their ability to function within a community in order to determine service needs and formulate recommendations for treatment. The required provider of the service is a QMHP, QAP or LMHP for rendering a diagnosis.

Key components of the Behavioral Health Assessment include:

- Risk assessment to determine emergency, urgent, and/or routine need for services
- Documentation of presenting problem, brief history, current medications, current medical conditions and current symptoms
- Formulation of a diagnosis by a LMHP
- Development of initial treatment recommendations

When billing the Behavioral Health Assessment the format of the evaluation must include the following:

- Presenting problem and referral source
- Brief history of previous psychiatric/substance use disorder treatment including type of admission
- Current medications
- Current mental health symptoms
- Current substance use
- Current medical conditions
- Diagnoses, including mental disorders, medical conditions and notation for psychosocial and contextual factors
- Functional assessment using a DMH approved instrument
- Identification of urgent needs (suicide, personal safety, risk to others)
- Initial treatment recommendations
- Initial treatment goals to meet immediate needs within the first 45 days of service
- Signature and title of all service providers

Limitations for Behavioral Health Assessment

The behavioral health assessment procedure code H0002 may be billed in the following situations:

- Level of care transition summary when persons are moving from one level of care to another
- Additional evaluation activities needed when an individual transfers from one CPR provider to another, or is admitted to a new CPR provider less than 11 months since the last intake or annual evaluation was completed
- Evaluation activities for persons admitted to CPR through the Disease Management (DM) 3700 program
- Time spent completing a functional assessment, as applicable. A QMHP may bill up to two (2) units of procedure code H0002 and the billable time must be the actual time spent completing the functional assessment and may vary from one person to another.

Procedure Code	Description
H0002	Behavioral Health Assessment
H0002 GT	Behavioral Health Assessment (Telehealth)

2.10.D Crisis Prevention and Intervention

Crisis prevention and intervention services are available 24 hours a day on an unscheduled basis to the participant. The services are designed to resolve the presenting crisis, provide support and assistance, develop symptomatic relief and to facilitate return to routine, adaptive functioning.

Key service functions for crisis prevention and intervention include, but are not limited to:

- Interacting with the identified individual and their family members/natural supports, legal guardian or a combination of these
- Specifying factors that led to the individual's crisis state, when known
- Identifying maladaptive reactions exhibited by the individual
- Evaluating potential for rapid regression
- Attempting to resolve the crisis
- Referring the individual for treatment in an alternative setting, when indicated

The service must be provided by a QMHP or QAP.

Non-medical staff providing crisis prevention and intervention shall have immediate, 24 hour telephone access to consultation with a physician/physician extender.

Limitations for Crisis Prevention and Intervention

Reimbursement for crisis prevention and intervention is not allowable when the service is provided by the individual's CSS.

Documentation Requirements for Crisis Prevention and Intervention

The following written documentation must be maintained in the individual's clinical record for all services billed:

- Description of the precipitating event(s)/situation when known
- Description of the individual's mental status
- Interventions initiated to resolve the individual's crisis state
- Individual's response to intervention
- Individual's disposition
- Planned staff follow-up
- Other documentation requirements for each session, service and activity as specified in **Section 2.3** of this manual.

Procedure Code	Description
H2011	Crisis Prevention and Intervention

2.10.E Medication Services

Medication services consist of goal-oriented interaction with the individual regarding the need for medication and management of a medication regimen.

Key service functions include, but are not limited to:

- Review of the individual's presenting condition
- Mental status exam
- Review of symptoms and medication side effects
- Review of the individual's functioning
- Review of the individual's ability to self-administer medication
- Education on the effects of medication and its relationship to the individual's mental illness and their choice of medication
- Prescription of medications when indicated

This service must be provided by a physician/physician extender (licensed APRN, physician assistant, assistant physician, psychiatric resident and psychiatric pharmacist) subject to guidelines and limitations promulgated for each specialty in statutes and administrative rules. Medication services must occur at least every six (6) months for individuals taking medications to treat a mental health condition. Review of relevant documentation in the individual record, such as progress notes and treatment plan reviews, shall constitute the review and evaluation.

Individuals requiring or requesting medication shall be seen by a qualified staff person within 15 days or sooner, if clinically indicated. All efforts shall be made to ensure established psychotropic medications are continued without interruption.

Definitions for the CPT codes for billing of medication services are described in the guideline section of the CPT manual. Refer to the definitions and explanations given for the use of the codes when determining the level of service to be used for each individual.

The medication services procedure codes may also have modifiers to distinguish when the service is provided by a physician/physician extender, when the procedure is delivered through telemedicine and when the procedure is delivered by a prescriber on an ACT team.

Limitations for Medication Services

CPT procedure codes 99202-99205, 99212-99215, 99334, 99335, 99341-99345 and 99347-99350 are per event codes and are limited to one unit per day, per participant. CPT procedure code 90792 is a 15 minute unit of service and is limited to two (2) hours (eight (8) units) per day, per participant and three (3) hours (12 units) per year, per participant. None of these procedure codes may be billed on the same date of service for the same participant as any of the other procedure codes.

Documentation Requirements for Medication Services

The following written documentation must be maintained in the individual's clinical record:

- Description of the individual's presenting condition
- Pertinent medical and psychiatric findings
- Observations and conclusions
- Any side effects of medication as reported by the individual
- Actions and recommendations regarding the individual's ongoing medication regimen
- Pertinent information reported by family members/natural supports regarding a change in the individual's condition or an unusual or unexpected occurrence in the their life, or both
- Additional items as required for each service, session, or activity as specified in [Section 2.3](#) of this manual

2.10.F Medication Administration

Medication administration is designed to assure the appropriate administration and continuing effectiveness of medication(s) being prescribed for a mental health or substance use disorder.

Key service functions for medication administration include:

- Administering therapeutic injections of medication (subcutaneous or intramuscular)
- Monitoring lab tests/levels, including consultation with the prescriber(s), individual served and community support specialist
- Educating individuals about their medications
- Recording individuals' initial histories and vital signs
- Ensuring medication is taken as prescribed
- Monitoring side effects of medication, including the use of standardized evaluations
- Monitoring prescriber's orders for treatment modifications and educating the individual served
- Coordinating medication needs with the individual served, their family/natural supports, as appropriate, and pharmacy staff, including the use of drug programs for the indigent (does not include routine placing of prescription orders and refills with pharmacies)
- Delivering medication to the individual's home

This service must be provided by a physician/physician extender, RN or LPN.

Limitations for Medication Administration

Medication administration is limited to four (4) hours (16 units) per day, per individual.

Documentation Requirements for Medication Administration

Documentation requirements are specified in [Section 2.3](#) of this manual.

Procedure Code	Description
H2010	Medication Administration

2.10.G Metabolic Syndrome Screening

Metabolic syndrome screening is an annual screening of adults and children/youth enrolled in CPR, Behavioral Health Healthcare Home or identified through the DM 3700 project. The screening is performed by a licensed nurse (RN or LPN) and screens for the following risk factors:

- Obesity
- Hypertension
- Hyperlipidemia
- Diabetes

The screening is required for children/youth and adults receiving antipsychotic medications or enrolled in the Behavioral Health Healthcare Home or for adults identified and enrolled through the DM 3700 project. This service is optional for all other individuals in the CPR program and, if provided, must be completed as specified in this section. Key service functions shall include, but are not limited to:

- Taking and recording vital signs
- Conducting lab tests to assess lipid levels, blood glucose levels and/or HgbA1c
- Obtaining results of recently completed lab tests from other health care providers to assess lipid levels, blood glucose levels and/or HgbA1c
- Recording the results of the metabolic screening in the health information platform approved by DMH

Limitations for Metabolic Syndrome Screening

Metabolic Syndrome Screening is limited to one (1) screening per individual, per 90 days; or more frequently if medically necessary.

Documentation Requirements for Metabolic Syndrome Screening

Documentation must reflect completion of the Metabolic Syndrome Screening and Monitoring tool and a summary progress note.

Procedure Code	Description
H2010 TD	Metabolic Screening – RN
H2010 TE	Metabolic Screening – LPN

2.10.H Community Support

Community support is a comprehensive service designed to reduce an individual's disability resulting from a mental illness, emotional disorder and/or substance use disorder and restore functional skills

of daily living, principally by developing natural supports and solution-oriented interventions intended to achieve the recovery/resiliency as identified in the goals and/or objectives in the individual treatment plan.

This service may be provided to the individual's family/natural supports when such services are for the direct benefit of the individual served, in accordance with needs and goals identified in the treatment plan, to assist in the individual's recovery/resiliency. Most contact occurs in community locations where the individual lives, works, attends school and/or socializes.

Key service functions include, but are not limited to:

- Developing recovery goals and identifying needs, strengths, skills, resources and supports and teaching individuals how to use them to support recovery; identifying barriers to recovery, and assisting individuals in the development and implementation of plans to overcome them.
- Helping individuals restore skills and resources negatively impacted by their substance use disorder and/or co-occurring mental illness or emotional disorder including, but not limited to:
 - Seeking or successfully maintaining employment or volunteering including, but not limited to, communication, personal hygiene and dress, time management, capacity to follow directions, planning transportation, managing symptoms/cravings, learning appropriate work habits and identifying behaviors that interfere with work performance.
 - Maintaining success in school including, but not limited to, communication with teachers, personal hygiene and dress, age appropriate time management, capacity to follow directions and carry out school assignments, appropriate study habits and identifying and addressing behaviors that interfere with school performance.
 - Obtaining and maintaining housing in the least restrictive setting including, but not limited to, issues relating to nutrition, meal preparation and personal responsibility.
- Supporting and assisting individuals in crisis to access needed treatment services to resolve the crisis.
- Continuing recovery planning and discharge planning with individuals receiving services who are hospitalized for medical or behavioral health reasons.
- Assisting individuals, other natural supports and referral sources in identifying risk factors related to relapse in mental illness and/or substance use disorders, developing strategies to prevent relapse and otherwise assisting individuals in implementing those strategies.
- Promoting the development of positive support systems by providing information to family members/natural supports, as appropriate, regarding mental illness, emotional disorders, and/or substance use disorders and ways they can be of support to their family member's recovery. Such activities must be directed toward the primary well-being and benefit of the individual served.
- Developing and advising individuals on implementing lifestyle changes needed to cope with the side effects of psychotropic medications and/or to promote recovery/resiliency from

the disabilities, negative symptoms and/or functional deficits associated with a mental illness, emotional disorder and/or substance use disorder.

- Advising individuals on maintaining a healthy lifestyle including, but not limited to, recognizing the physical and physiological signs of stress, creating a self-defined daily routine that includes adequate sleep and rest, walking or exercise, appropriate levels of activity and productivity, involvement in creative or structured activity that counteract negative stress responses, learning to assume personal responsibility and care for minor illnesses and knowing when professional medical attention is needed.

Limitations for Community Support

The CPR provider shall ensure that an adequate number of appropriately qualified staff are available to provide community support services and functions. Caseload size may vary according to the acuity, symptom complexity and needs of participants. An individual or their parent/guardian has the right to request an independent review by the CPR director if they believe individual needs are not being met. If the CPR director deems it necessary, caseload size or other changes may be implemented. The supervisory-to-staff ratio shall be based on the needs of individuals being served, focusing on successful outcomes and satisfaction with services and supports as expressed by individuals. The organization shall have policies and procedures for monitoring and adjusting caseload size and ensure there is documented, ongoing supervision of clinical and direct service staff.

Community support services are limited to eight (8) hours (32 units) per day, per individual. The total number of hours of community support allowed per month, per individual is 50 hours (200 units.)

Documentation Requirements for Community Support

In order to bill for community support, written documentation must be maintained in the individuals clinical record for each community support session, service, or activity. See [Section 2.3](#) of this manual. Additional documentation must include:

- Phone contacts
- Pertinent/significant information reported by family members/natural supports regarding a change in the individual's condition and/or an unusual or unexpected occurrence in their life.

Procedure Code	Description
H0036	Community Support

2.10.I Intensive Community Psychiatric Rehabilitation

Intensive Community Psychiatric Rehabilitation (ICPR) is separate and distinct from other CPR services. The individual treatment plan shall specify interventions and supports to be provided by ICPR staff that are separate from other CPR services to prevent duplication of services. Services are designed to help individuals who are experiencing a severe psychiatric condition, alleviating or

eliminating the need to admit them in to a psychiatric inpatient setting or a restrictive living environment. ICPR is a comprehensive, time limited, community-based service for individuals who are exhibiting symptoms that interfere with individual/family life in a highly disabling manner.

ICPR in all settings (children/youth and adult) must be approved by DMH prior to implementation. Written proposals shall be submitted to the DMH in accordance with established protocol.

ICPR is intended for the following:

- Individuals who would be hospitalized without the provision of intensive community-based interventions
- Individuals who have extended or repeated hospitalizations
- Individuals who have psychiatric crisis episodes
- Individuals who are at risk of being removed from their home or school to a more restrictive environment
- Individuals who require assistance in transitioning from a highly restrictive setting to a community-based alternative, including specifically individuals being discharged from inpatient psychiatric settings who need intensive CPR services and may require assertive outreach and engagement

Treatment teams deliver services that will maintain the individual within the family and significant support systems and assist them in meeting basic living needs and age appropriate developmental needs.

To be eligible for ICPR, the individual must meet the admission criteria defined in [Section 2.8](#) of this manual and at least one (1) of the following criteria:

- Is being discharged from a DMH facility or bed funded by DMH
- Has had extended or repeated psychiatric inpatient hospitalizations or crisis episodes within the past six (6) months
- Has received services in multiple out-of-home residential settings due to their mental disorder
- Is at risk of being removed from their home, school or other community living situation

An ICPR treatment team coordinates a comprehensive array of services available to the individual through the CPR program. Other services shall be provided, as clinically appropriate, to meet individual needs. However, these services shall not duplicate services that are being provided on site in an ICPR residential setting. Each team shall include the following:

- Staff required to provide specific services identified on the individual treatment plan
- The individual receiving services and family members or other natural supports, if developmentally appropriate

The treatment team shall be supervised by a QMHP.

ICPR shall include:

- Multiple face-to-face contacts on a weekly basis, and may require contact on a daily basis, as required for each service type

- Services that are available 24 hours per day, seven (7) days per week for programs that require daily services
- Crisis response services that may be coordinated with an existing crisis system

The amount and frequency of services is based upon the individual's assessed acuity and need.

A crisis prevention plan shall be developed for each individual, including clinical issues that may impact their transition to less intensive services. Regular treatment plan reviews shall occur to ensure individuals are receiving the appropriate level of services to meet needs and goals.

Individuals are no longer in need of intensive services when:

- There is a reduction of severe symptoms
- They are able to function without intensive services
- They choose to no longer receive intensive services

Documentation Requirements for Intensive Community Psychiatric Rehabilitation Services

For individuals currently enrolled in the CPR program, the following additional documentation is required upon admission to ICPR:

- Verification they meet admission criteria
- Acuity level
- Treatment plan update indicating the higher level of service the individual will be receiving

For individuals newly admitted directly from the community into ICPR, an intake evaluation must be completed to substantiate acuity and criteria for admission. The initial assessment must be completed within 30 days of admission, except for individuals admitted provisionally.

Treatment plans shall be developed within 45 days after completion of the initial assessment. At a minimum, quarterly treatment plan reviews shall occur to ensure individuals are receiving the appropriate level of services to meet needs and goals.

Additionally, each individual shall have a psychiatric evaluation at admission. For individuals discharged from inpatient hospitalization into ICPR, a psychiatric evaluation completed at the facility/hospital may initially be accepted.

Upon change from ICPR services, a transition summary must be completed by a QMHP and included in an updated treatment plan.

Intensive Community Psychiatric Rehabilitation for Children and Youth

Services are medically necessary to maintain a child with a SED in their natural home, or maintain a child with a serious mental illness or SED in a community setting who has a history of ineffectual outcomes in multiple community settings and/or the presence of ongoing risk of harm to self or others, which would otherwise require long-term psychiatric hospitalization. Clinical interventions are provided by a multidisciplinary treatment team on a daily basis, and the interventions must be available 24 hours per day, seven (7) days per week for stabilization purposes.

When an individual is receiving ICPR services, it is vital that the parents/guardians be actively involved in the program if the child is to receive the full benefit of the program. Services may be provided to the individual's family and other natural supports when such services are for the direct benefit of the individual, in accordance with their needs and treatment goals identified in their individual treatment plan, and for assisting in the individual's recovery.

Services shall include, but are not limited to:

- Medication services/medication administration
- Ongoing behavioral health assessment and diagnosis
- Monitoring to assure individual safety
- Individual and group counseling
- Community support

The ICPR multidisciplinary team shall include the following staff, based on the needs of the individual served:

- Physician, psychiatrist, child psychiatrist, psychiatric resident, assistant physician, physician assistant or APRN
- QMHP
- RN
- LPN
- CSS
- Individuals with a high school diploma, or equivalent certificate, under the direction and supervision of a QMHP

Children and youth receiving ICPR must be enrolled in CIMOR, assigned to the CPS Youth CPR service category, and assigned to the intensive level of care.

Intensive Community Psychiatric Rehabilitation for Adults in Non-Residential Settings

Services are delivered by teams using one (1) of the following methods:

- Linking and transitioning individuals from acute or long-term services to less intensive treatment. The time frame for services is approximately 90 days or less, but varies according to individual needs.
- Modified ACT, as approved by DMH. The time frame varies based on individual needs.
- Intensive wrap-around stabilization services for individuals with substantial mental health needs who may otherwise require inpatient hospitalization. The expected period of engagement is approximately 90 days or less, but varies according to individual needs.

Teams may be designated exclusively for individuals in ICPR or be mixed teams serving individuals in ICPR and rehabilitation services.

Adults receiving ICPR services must be enrolled in CIMOR, assigned to the CPS Adult CPR service category, and assigned to the rehabilitation level of care.

Limitations for Adults in Non-Residential Settings

ICPR is a per diem service rate and is limited to one (1) unit per day.

CPR Community Support services (procedure code H0036) cannot be billed while an individual is being served by an ICPR non-residential team.

ICPR for residential settings (procedure codes H0037 HK, H0037 TF, H0037 TG) cannot be billed while the individual is being served by an ICPR non-residential team.

All other CPR services, including medication services, may be provided and billed according to individualized need.

Documentation Requirements for Adults in Non-Residential Settings

A DMH-approved functional assessment or treatment plan review must be completed quarterly and documented in the individual record. Refer to [Section 2.3](#) of this manual.

Documentation must support clinical necessity for intensive services beyond 90 days.

Procedure Code	Description
H0037	Intensive CPR

Intensive Community Psychiatric Rehabilitation for Transition Age Youth (Ages 16-25) in Non-Residential Settings

Services are delivered by transdisciplinary specialty teams using intensive wrap-around stabilization for individuals with substantial mental health and/or co-occurring needs, with the primary diagnosis being a mental disorder.

Services are for individuals who may otherwise require inpatient hospitalization. The period of engagement varies based upon individual needs as specified in the treatment plan.

A comprehensive assessment must be completed within 30 days of admission. An individual treatment plan shall be developed within 45 days of completion of the assessment and shall be updated at least quarterly.

Procedure Code	Description
H0037	Intensive CPR

Limitations for Transition Age Youth in Non-Residential Settings

Transition-Age Youth (ages 16 to 25) in Non-Residential Settings is a per diem service rate and is limited to one (1) unit per day.

CPR community support services (procedure code H0036) shall not be billed while an individual is being served by an ICPR non-residential team.

ICPR for residential settings (H0037 HK, H0037 TF, H0037 TG) shall not be billed while the individual is being served by an ICPR non-residential team.

All other CPR services, including medication services, may be provided and billed according to individualized need.

Documentation for Transition Age Youth in Non-Residential Settings

Refer to [Section 2.3](#) of this manual. Documentation must support clinical necessity for intensive services beyond 90 days.

Intensive Community Psychiatric Rehabilitation for Evidence-Based Practices For Youth

Evidence-based practices (EBP) for youth services involve proven treatment supports for children and youth to address specific behavioral health needs. The selected EBP is based on the individual's needs and desired outcomes as identified on the treatment plan. EBPs currently billable include Functional Family Therapy, Multi-Systemic Therapy and Dialectical Behavior Therapy.

Additional EBPs may be added as billable under procedure code H0037 HA, but must be approved by DMH prior to implementation. An approved EBP will contain activities such as:

1. Extensive monitoring and data collection
2. Specific skills-training components in a prescribed or natural environment
3. Prescriptive responses to psychiatric crisis and/or frequent contact with the child and/or family, in addition to the arranged therapy sessions

Limitations for Evidence-Based Practices for Youth

EBP is a daily rate that cannot be billed in conjunction with H0037 or with H0037 TG HA. Evidence-based practices billable to this procedure code are limited to: Functional Family Therapy, Multi-Systemic Therapy and Dialectical Behavior Therapy. Additional evidence-based practices may be added as billable under this procedure code.

Documentation Requirements for Evidence-Based Practices for Youth

Refer to [Section 2.3](#) of this manual and, at a minimum, a daily note for support services in EBP and providers must follow requirements for fee-for-service Medicaid (e.g. therapy.)

Procedure Code	Description
H0037 HA	Evidence Based Practices

Intensive Community Psychiatric Rehabilitation for Children/Youth in Residential Settings – Treatment Family Home-Based Services

Treatment Family Home-Based Services (TFH) are designed for children whose therapeutic needs cannot be met in their natural home or an alternative therapeutic environment is required for transition back to their home or least restrictive setting.

Intensive therapeutic interventions are provided to improve the child's functioning and prevent them from being removed from their natural home and placed into a more restrictive residential treatment setting due to a SED.

A maximum of three (3) children may receive services in a TFH, subject to licensed capacity.

Providers must complete extensive, specialized training required by DMH and meet DMH licensure requirements as specified in [9 CSR 40-1](#) and [9 CSR 40-6](#), as applicable, prior to providing services.

Training includes, but is not limited to:

- Forty (40) hours minimum for Tool Kit training
- Level 1 Medication Aide training
- CPR/First Aid
- Non-Violent Crisis Intervention (NVCi)
- Home Study

The provider shall participate in pre-placement and ongoing meetings with the child's CPR treatment team and assist in development of the treatment plan. The provider is responsible for implementing the treatment plan and maintaining contact with the child's natural parent/guardian and completing documentation as required by the department.

Services and supports are individualized and strength-based to meet the needs of the child and family across life domains to promote success, safety, and permanence in the home, school, and community. Therapeutic interventions target the child's serious mental health issues and promote positive development and healthy family functioning.

Children must meet CPR admission criteria and their behavior must be sufficiently under control to live safely in a community setting with appropriate support.

Staff of the CPR program who supervise the child's services must be available 24 hours per day, seven (7) days per week to assist the provider if a crisis situation occurs.

Placement, duration, and intensity of services is based on the specific needs of each child, and as specified in the department contract.

Limitations for Children/Youth in Residential Settings – Treatment Family Home-Based Services

TFH is a daily rate that cannot be billed in conjunction with the following services: H0037 TF HA, H0037 TG HA.

Documentation Requirements for Children/Youth in Residential Settings – Treatment Family Home-Based Services

Services shall be documented as specified in [Section 2.3](#) of this manual.

Procedure Code	Description
H0037 HK HA	Treatment Family Home Based Services

Intensive Community Psychiatric Rehabilitation for Children/Youth in Residential Settings – Professional Parent Home-Based Services

Professional Parent Home-Based Services (PPH) are designed for children whose therapeutic needs cannot be met in their natural home or an alternative therapeutic environment is required for transition back to their home or least restrictive setting.

Intensive therapeutic interventions are provided to improve the child's functioning and prevent them from being removed from their natural home and placed into a more restrictive residential treatment setting.

A PPH must meet CPR admission criteria and the behavior of the children receiving services must be sufficiently under control to live safely in a community setting with appropriate support.

Each child will have an individual treatment plan developed collaboratively with the family, child, natural supports, agencies and community partners.

One (1) child may receive services in a PPH.

Providers must complete extensive, specialized training required by DMH and meet DMH licensure requirements as specified in [9 CSR 40-1](#) and [9 CSR 40-6](#), as applicable, prior to providing services.

The provider shall participate in preplacement and ongoing meetings with the child's CPR treatment team and assist in development of a treatment plan for the child. The provider is responsible for implementing the treatment plan and maintaining contact with the child's natural parent/guardian and completing documentation as required by the department.

Services and supports are individualized and strength-based to meet the needs of the child and family across life domains to promote success, safety, and permanence in the home, school, and community. Therapeutic interventions target the child's serious mental health issues and promote positive development and healthy family functioning.

Staff of the CPR program who supervise the child's services must be available 24 hours a day, seven (7) days per week to assist the provider if a crisis situation occurs.

Placement, duration, and intensity of services is based on the specific needs of each child.

Providers shall perform tasks and functions including, but not limited to:

- Pre-placement meetings and contact
- Participation in treatment planning
- Provision of a documented and monitored therapeutic milieu
- Treatment implementation as outlined in the plan
- Participation in treatment team meetings
- In-home therapeutic, social and recreational activities
- Administration of medication(s)
- Community-based therapeutic, social and recreational activities
- Transportation

- Participation in the day treatment program at least two (2) days per week or presence in the school as outlined by the individualized treatment plan
- Documentation
- Generalization from PPH to natural home
- Contact with child’s family and/or other natural supports
- Community relations
- Advocacy

Providers must complete standard training as specified for TFH, and in addition, must complete enhanced training which includes:

- Training on implementation of a behavior support plan developed by a Board Certified Behavior Analyst
- Family support provider training
- Self-help skills training
- CPR orientation/training
- Monthly in-service trainings
- Additional training made available which may include, but is not limited to, Motivational Interviewing, person-centered planning, Dialectical Behavior Therapy and trauma-informed care

Limitations for Children/Youth in Residential Settings – Professional Parent Home-Based Services

PPH is a daily rate and cannot be billed in conjunction with the following services: H0037 HK HA, H0037 TG HA.

Documentation Requirements for Children/Youth in Residential Settings – Professional Parent Home-Based Services

PPH services shall be documented as specified in [Section 2.3](#) of this manual.

Procedure Code	Description
H0037 TF HA	Professional Parent Home-Based Services

Intensive Community Psychiatric Rehabilitation for Children’s Inpatient Diversion

Children’s Inpatient Diversion (CID) is a full array of intensive clinical services provided to individuals in a highly structured therapeutic setting. Services are designed to restore the individual to a prior level of functioning, decrease risk of harm, and prevent hospitalization. CID services include:

- Emergency medical services must be available on site or in close proximity.
- A psychiatrist must supervise services which are delivered by a multi-disciplinary treatment team.
- Licensed nursing staff must be available on a daily basis.
- Licensed occupational and recreational therapists must be available based on individual needs.

- The provision of services is limited to certified or deemed-certified CPR programs for children and youth. The service must be accredited by a national accrediting body approved by DMH.

There shall be one (1) staff person for every two (2) individuals served during waking hours. The ratio for staff to individuals served may decrease to one (1) staff to six (6) individuals during sleeping hours.

Limitations for Children's Inpatient Diversion

CID is a daily rate and cannot be billed in conjunction with procedure codes: H0037 TF HA, H0037 HK HA, H0037 HA or H0037.

Documentation Requirements for Children's Inpatient Diversion

CID services shall be documented as specified in [Section 2.3](#) of this manual.

Procedure Code	Description
H0037 TG HA	Children's Inpatient Diversion

Intensive Community Psychiatric Rehabilitation – for Adult Inpatient Diversion

A full array of intensive clinical services are provided to adults in a highly supervised, 24 hour structured therapeutic setting. Services are designed to restore the individual to a prior level of functioning, decrease risk of harm and prepare for transition to a less restrictive setting. Services include, but are not limited to, nursing, community support, psychosocial rehabilitation and treatment for co-occurring disorders.

Emergency medical services must be available on site or in close proximity.

Intensive therapeutic services must be provided in a coordinated effort under the direction of a psychiatrist. Other staff on the treatment team includes licensed nurses, licensed psychologists, social workers, counselors, psychosocial rehabilitation specialists and other trained supportive staff.

The staffing ratio for daytime and evening hours shall be one (1) staff to six (6) individuals served, and one (1) staff to eight (8) individuals served during nighttime hours.

Limitations for Adult Inpatient Diversion

The provision of adult inpatient diversion services is limited to CPR programs for adults. The service must be accredited by a national accrediting body approved by DMH.

Psychiatric/physician services and medications are billed separately from adult inpatient diversion.

Programs shall not exceed 16 beds.

Documentation Requirements for Adult Inpatient Diversion

Adult inpatient diversion services shall be documented as specified in [Section 2.3](#) of this manual.

Procedure Code	Description
H0037 TG HB	Adult Inpatient Diversion

Intensive Community Psychiatric Rehabilitation for Residential—Clustered Apartments

Residential – clustered apartments include medically necessary services, interventions, and supports provided on site at the individual's place of residence as an alternative to long-term hospitalization. Residential settings are structured to meet individual needs to ensure safety and prevent the individual's return to a more restrictive setting for services. Services include, but are not limited to, supportive rehabilitation services around specific activities of daily living or when individuals are in crisis and, based on specific individual need, room checks and monitoring points of ingress/egress. Each apartment unit must be single occupancy, with no roommates.

Staff providing services/supports shall be supervised by a QMHP. Staff must be at least 18 years of age and have a minimum of a high school diploma or equivalent certificate. Two (2) years of direct health care experience, or a bachelor's degree in behavioral sciences, is preferred.

Staff must be systematically trained to provide intensive interventions and supports to reduce the symptoms of mental illness, and provide de-escalation and intervention techniques to individuals in a psychiatric crisis who are exhibiting behaviors potentially dangerous to themselves or others. A training plan must be in place for each staff person identifying specific topics and frequency of refresher training on each topic, including documentation of course completion.

Staff shall be available on a full- or part-time basis in accordance with the agency's written proposal approved by DMH. Staff providing services shall be located on-site, within a five (5) mile radius of the apartment, or within a 10 minute drive of the clustered apartment.

Clustered apartments are most appropriate for individuals who—

- Are unable to tolerate congregate living arrangements in which the presence of other individuals in their immediate living area tends to precipitate psychiatric relapse, aggression or other behaviors associated with a risk of re-hospitalization.
- May possess sufficient competence in activities of daily living such that observation and oversight 24 hours per day, seven (7) days per week are unnecessary, enabling limited independence while in the apartment setting.

Limitations for Residential—Clustered Apartments

Residential clustered apartments are limited to providers who operate certified CPR programs for adults who are approved by DMH to provide this service. The team of staff providing this service must be trained to provide the services described above and must be supervised by a QMHP. Services cannot be billed on the same day as procedure codes H0037, H0037 TF or H0037 TG. Individuals must be enrolled in the CPR-Rehabilitation level of care to receive this service.

Documentation Requirements for Residential – Clustered Apartments

ICPR Clustered Apartments is a daily (per diem) unit rate. For each day this service is billed, the

medical record must reflect documentation of direct (face-to-face) services and supports provided that day. Examples of documentation include:

- Daily summary progress notes
- Weekly summary progress notes
- Group notes
- Shift change notes
- Safety monitoring notes
- Individualized progress notes documenting interventions including crisis assistance, conflict management, behavior redirection, prompting or reminders.

Exact clock time is not required in the documentation. In addition, a crisis prevention and intervention plan must be present for each individual being served in an ICPR Clustered Apartment setting.

Procedure Code	Description
H0037 HK	ICPR Residential – Clustered Apartments

Intensive Community Psychiatric Rehabilitation for Intensive Residential Treatment Setting

The ICPR intensive residential treatment setting program shall comply with the DMH licensing regulations specified in [9 CSR 40-1](#), as applicable. All individuals must have an individual treatment plan and shall receive services as specified in [9 CSR 40-1.075](#). The program shall also comply with [9 CSR 40-4.001](#).

An extensive array of medically necessary services, interventions and supports are provided on-site in an intensive residential treatment setting (IRTS) to assist the individual in managing their psychiatric symptoms, functional deficits, co-occurring disorders and problematic behaviors. The program provides a high level of services, structure, oversight and support for adults with serious mental illness who are transitioning from an inpatient psychiatric hospital to the community, or are at risk of returning to inpatient care due to their clinical status or need for increased support.

Supports and rehabilitation services related to an individual's needs for activities of daily living and suicide and crisis prevention and intervention must be provided. Rehabilitation services may be available on-site and in the community to promote psychiatric recovery and a reduction in symptoms in order for the individual to progress toward more independent living.

Five (5) to 16 adults may be served in an IRTS which is most appropriate for individuals who:

- Can tolerate regular interaction with their peers, but have significant difficulties with activities of daily living
- May require around-the-clock observation and oversight
- Require periodic redirection from staff to avoid behaviors potentially harmful to themselves or others

Limitations for Intensive Residential Treatment Setting

IRTS services are limited to certified CPR programs for adults that are approved by DMH to provide this service. Each program shall have a director who is responsible for making decisions regarding program operations. The team of staff providing this service must be trained to provide the services described above and must be supervised by a QMHP.

This service cannot be billed on the same day as procedure codes H0037, H0037 HK or H0037 TG. Individuals must be enrolled in the CPR-Rehabilitation level of care to receive this service.

Documentation Requirements for Intensive Residential Treatment Setting

IRTS is a daily (per diem) unit rate. For each day this service is billed, the medical/clinical record must reflect documentation of direct (face-to-face) services and supports provided that day. Examples of documentation include:

- Daily summary progress notes
- Weekly summary progress notes
- Group notes
- Shift change notes
- Safety monitoring notes
- Individualized progress notes documenting interventions including crisis assistance, conflict management, behavior redirection, prompting or reminders.

Exact clock time is not required in the documentation. In addition, a crisis prevention and intervention plan must be present for each individual being served in an IRTS.

Procedure Code	Description
H0037 TF	ICPR Intensive Residential Treatment Setting

Intensive Community Psychiatric Rehabilitation for Psychiatric Individualized Supported Living

The psychiatric individualized supported living (PISL) program shall comply with the DMH licensing regulations specified in **9 CSR 40-1**, as applicable. All individuals must have an individual treatment plan and shall receive services as specified in **9 CSR 40-1.075**. The program shall also comply with **9 CSR 40-4.001**.

PISL provides a high level of services, structure, oversight, and support for adults with serious mental illness who are transitioning from an inpatient psychiatric hospital to the community, or are at risk of returning to inpatient care due to their clinical status or need for increased support.

An extensive array of medically necessary services, interventions and supports are provided on site to assist the individual in managing their psychiatric symptoms, functional deficits, co-occurring disorder and problematic behaviors.

Supports and rehabilitation services related to an individual's needs for activities of daily living and suicide and crisis prevention and intervention must be provided. Rehabilitation services may be

available on-site and in the community to promote psychiatric recovery and a reduction in symptoms in order for the individual to progress toward more independent living.

The program provides services for one (1) to four (4) adults and is most appropriate for individuals who:

- Have intermittent difficulty tolerating other individuals in their immediate living environment
- Require access to an individual bedroom to promote psychiatric wellness and reduce the potential for aggression or other behaviors associated with a risk of re-hospitalization
- Have substantial difficulties with activities of daily living and require around-the-clock observation and oversight
- Require daily redirection from staff to avoid behaviors potentially harmful to themselves or others

Limitations for Psychiatric Individualized Supported Living

PISL is limited to providers who operate certified CPR programs for adults who are approved by DMH to provide this service. The team of staff must be trained to provide the services described above and must be supervised by a QMHP. This service cannot be billed on the same day as procedure codes H0037, H0037 HK or H0037 TF. Individuals must be enrolled in the CPR-Rehabilitation level of care to receive this service.

Documentation Requirements for Psychiatric Individualized Supported Living

PISL is a daily (per diem) unit rate. For each day that this service is billed, the medical record must reflect documentation of direct (face-to-face) services and supports provided that day. Examples of documentation include:

- Daily summary progress notes
- Weekly summary progress notes
- Group notes
- Shift change notes
- Safety monitoring notes
- Individualized progress notes documenting interventions including crisis assistance, conflict management, behavior redirection, prompting or reminders.

Exact clock time is not required in the documentation. In addition, a crisis prevention and intervention plan must be present for each individual being served in an IRTS.

Procedure Code	Description
H0037 TG	ICPR Psychiatric Individualized Supported Living

2.10.J Peer Support

Peer support assists individuals in their recovery from a behavioral health disorder in a person-centered, recovery-focused manner. Individuals direct their own recovery and advocacy processes

to develop skills for coping with and managing their symptoms, and identify and utilize natural support systems to maintain and enhance community living skills. Services are directed toward achievement of specific goals defined by the person served and specified in the individual treatment plan.

Services are provided by Certified Peer Specialists who have at least a high school diploma or equivalent certificate, complete applicable training and testing as required by DMH, and are supervised by a QMHP. Certified Peer Specialists shall be considered a member of the treatment team and shall participate in staff meetings/discussions related to services, but they cannot be the only staff assigned to work with an individual.

Peer support services shall be provided in a manner that reflect the core competencies, principles, and values identified in the publication, "[**Core Competencies for Peer Workers in Behavioral Health Services**](#)", developed Substance Abuse and Mental Health Services Administration (SAMHSA).

Job duties include, but are not limited to:

- Starting and sustaining mutual support groups
- Sharing lived experiences of recovery and promoting dialogues on recovery and resilience
- Teaching and modeling skills to manage symptoms
- Teaching and modeling skills to assist in solving problems
- Supporting efforts to find and maintain paid employment
- Using the stages in recovery concept to promote self-determination
- Assisting peers in setting goals and following through on wellness and health activities

Certified Peer Specialists use the power of peers to support, encourage and model recovery and resilience from behavioral health disorders in ways that are specific to the needs of each individual. Services may be provided on an individual or group basis and are designed to assist individuals in achieving the goals and objectives on their individual treatment plan or recovery plan. Activities emphasize the opportunity for individuals to support each other as they move forward in their recovery. Interventions may include, but are not limited to:

- Sharing lived experiences of recovery, sharing and supporting the use of recovery tools and modeling successful recovery behaviors
- Helping individuals recognize their capacity for resilience
- Helping individuals connect with other peers and their community at large
- Helping individuals who have behavioral health disorders develop a network for information and support
- Assisting individuals in making independent choices and taking a proactive role in their treatment
- Assisting individuals in identifying strengths and personal resources to aid in their recovery
- Helping individuals set and achieve recovery goals

Limitations for Peer Support

Certified Peer Specialists must work as part of a treatment team, but cannot be the only staff assigned to work with an individual.

The CPR provider shall ensure an adequate number of appropriately qualified staff are available to support the functions of the program.

Peer support services are limited to eight (8) hours, (32 units) per day, per individual. The total number of hours of peer support allowed per month, per individual is 50 hours (200 units.)

Documentation Requirements for Peer Support

Documentation Requirements for peer support are specified in [Section 2.3](#) of this manual.

Procedure Code	Description
H0038	Peer Support Services

2.10.K Psychosocial Rehabilitation

Psychosocial Rehabilitation (PSR) programs must be accredited by Commission on Accreditation of Rehabilitation Facilities (CARF) International, The Joint Commission, Council on Accreditation or other accrediting body recognized by DMH. If the PSR program is not accredited, department licensing rules specified in [9 CSR 40-1](#) and [9 CSR 40-9](#) shall apply, as applicable, until accreditation is obtained.

The CPR program shall provide or arrange transportation to and from the PSR site, and to and from various locations in the community, to provide individuals with opportunities for off-site training and rehabilitation in realistic settings.

Policies and procedures shall be implemented for intake screening, referral and assignment of individuals eligible for services. The policy and procedures are as follows:

- Intake policies and procedures shall define referral procedures to be followed for individuals determined ineligible for PSR services.
- The maximum wait time from an individual's initial contact with the PSR program to intake screening shall be 10 working days, or sooner, if clinically indicated.
- The intake screening shall determine the individual's need for PSR, functional strengths and weaknesses and transportation needs.
- PSR services shall be incorporated into the individual's treatment plan within 45 days of admission to the program.

Policies and procedures shall ensure program staff document measurable progress for individuals engaged in key services. Key services shall include, but are not limited to:

- Training/rehabilitation in community living skills
- Development of personal support systems through a group modality
- Prevocational training/rehabilitation provided directly by the program or through subcontract, including at a minimum:

- Interview and job application skills
- Therapeutic work opportunities
- Temporary employment opportunities

PSR services shall be structured and may occur during the day, evening, weekend or a combination of these, to effectively address the rehabilitation needs of individuals served. Services and activities are not limited to the program location/site. The program shall directly provide or ensure the following services available for individuals served:

- Opportunities for training and rehabilitation in daily living skills, including activities associated with meal preparation and laundry, at a minimum
- Off-site training/rehabilitation in community living skills
- Opportunities for family members/natural supports and advocates to participate in the planning, development, and evaluation of the PSR program

Documentation Requirements for Psychosocial Rehabilitation Services

Documentation of key services must include:

- A weekly note summarizing specific services rendered, the individual's involvement in and response to the services and relationship of the services to the treatment plan.
- Pertinent information reported by family members or other natural supports regarding a change in the individual's condition and/or an unusual or unexpected occurrence in their life.
- Daily attendance records, including each individual's actual attendance time and the activity or session attended (this information does not need to be integrated into the individual record). Attendance records must be available to DMH staff and other authorized representatives for audit and monitoring purposes, upon request.

Psychosocial Rehabilitation for Adults

PSR for adult services are for adults who need age-appropriate, developmentally focused rehabilitation. A combination of goal-oriented and rehabilitative services shall be provided in a group setting to assist individuals in developing personal support systems, social skills, community living skills and pre-vocational skills that promote community inclusion, integration and independence. Key service functions shall include, but are not limited to:

- Screening to evaluate the appropriateness of the individual's participation in the psychosocial rehabilitation (PSR)
- Addressing individualized program goals and objectives
- Enhancing independent living skills
- Addressing basic self-care skills
- Enhancing use of personal support systems

The director of the program must be a QMHP with three (3) years of relevant work experience.

All direct care staff must have a high school diploma or equivalent certificate.

Each PSR program shall have, at a minimum, a daily direct care staff ratio of one (1) staff person for each 16 individuals served unless program needs or the needs of individuals being served require otherwise.

At least one (1) staff person must be on duty at all times when individuals enrolled in PSR are present at the program.

Psychosocial Rehabilitation for Children and Youth

PSR for children and youth is a combination of goal-oriented and rehabilitative services provided in a group setting to improve or maintain the youth's ability to function as independently as possible within the family or community. Services shall be provided according to the individual treatment plan with an emphasis on community integration, independence and resiliency. Hours of operation shall be determined by the program based on capacity, staffing availability, geography and space requirements, but shall be no more than six (6) hours daily, per child.

The director shall be a QMHP with two (2) years experience working with children and youth. One (1) full time equivalent mental health professional shall be available during the provision of services.

The staffing ratios shall be based on the ages and needs of the children being served. For individuals between the ages of three (3) and 11, the staffing ratio shall be one (1) staff to four (4) individuals. For individuals between the ages of 12 and 17, the staffing ratio shall be one (1) staff to six (6) individuals. Other staff of the PSR team shall include the following, based on the needs of individuals being served:

- Registered nurse
- Occupational therapist
- Recreational therapist
- Rehabilitation therapist
- Community support specialist
- Certified family support provider
- Certified peer specialist

Key service functions shall include, but are not limited to:

- Assisting the child in gaining or regaining skills for community/family living such as personal hygiene, completing age-appropriate household chores and family, peer, and school activities.
- Developing interpersonal skills which provide a sense of participation and personal satisfaction (opportunities should be age and culturally appropriate daytime and evening activities which offer the chance for companionship, socialization, and skill building).
- Assisting the child and family in developing normative behaviors and expectations of relationships, and providing the opportunity to practice affiliated skills which can be valuable to an individual reestablishing family and personal support relationships.

Group sessions for parents/guardians may be provided to develop and enhance parenting skills. In these situations, the PSR services and expected goals and outcomes must be documented in the individual's treatment plan and clearly relate to their treatment and rehabilitation goals.

If a child is receiving Intensive CPR services H0037, they can also receive and bill for PSR service H2017 HA at the same time.

Limitations for Psychosocial Rehabilitation

PSR for adults or children and youth is limited to 10 hours, 40 units per day for these codes, or in combination with PSR illness management and recovery (IMR) H2017 TG.

Documentation Requirements for Psychosocial Rehabilitation

PSR services must be documented as specified in [Section 2.3](#) of this manual.

Procedure Code	Description
H2017	Psychosocial Rehabilitation
H2017 HA	Psychosocial Rehabilitation – Children/Youth

Psychosocial Rehabilitation Illness Management and Recovery

PSR illness management and recovery (IMR) services promote physical and mental wellness, well-being, self-direction, personal empowerment, respect and responsibility. Services shall be provided in individual and group settings using curriculum approved by DMH. Services must be delivered by staff who have completed required training.

Services shall be person-centered and strength-based and including, but not limited to:

- Psychoeducation
- Relapse prevention
- Coping skills training

CPR programs must be approved by DMH to provide this service. If a program is accredited by Clubhouse International and submits its accreditation report to DMH, it may be deemed as a PSR-IMR program by DMH.

Limitations for Psychosocial Rehabilitation Illness Management and Recovery

PSR-IMR is only covered for an agency that has been approved by DMH to provide this service. The maximum group size for PSR-IMR shall not exceed eight (8) individuals; however, if there are other curriculum-based approaches that suggest different group size guidelines, larger groups may be approved by DMH.

PSR-IMR services are limited to 10 hours, 40 units per day, either individually or in combination with PSR H2017.

Documentation Requirements for Psychosocial Rehabilitation Illness Management and Recovery

PSR-IMR services must be documented as specified in [Section 2.3](#) of this manual.

Procedure Code	Description
H2017 TG	PSR Illness Management and Recovery

2.10.L Individual Professional Psychosocial Rehabilitation and Group Professional Psychosocial Rehabilitation

Mental health interventions are provided on an individual or group basis. A skills-based approach is utilized to address identified behavioral problems and functional deficits related to a mental disorder that interferes with an individual's personal, family, or community adjustment.

Services must be provided by the following:

- A professional counselor licensed or provisionally licensed under Missouri law
- A licensed clinical social worker or master social worker licensed under Missouri law
- A licensed, provisionally licensed, or temporarily licensed psychologist under Missouri law
- A marital and family therapist licensed or provisionally licensed under Missouri law

Limitations for Individual Professional Psychosocial Rehabilitation and Group Professional Psychosocial Rehabilitation

PSR services for individuals and groups are only covered for an agency that is certified to provide a CPR program for adults and/or children and youth.

For Group Professional PSR, the maximum group size is one (1) professional to eight (8) individuals. This service may not be provided to individuals under the age of five (5.)

Individual Professional PSR services are limited to three (3) hours, 12 units per day, per individual.

Group Professional PSR services are limited to three (3) hours, 12 units per day, per individual.

Documentation Requirements for Individual Professional Psychosocial Rehabilitation and Group Professional Psychosocial Rehabilitation

Documentation requirements for PSR for individuals and groups are specified in [Section 2.3](#) of this manual.

Procedure Code	Description
H2017 HO	Individual Professional PSR
H2017 HQ HO	Group Professional PSR

2.10.M Physician Consultation/Professional Consultation

Physician consultation and professional consultation are medical services provided by a physician/physician extender. This service is intended to provide direction to treatment and consists of a review of an individual's current medication situation either through consultation with one (1)

staff person, or a team discussion(s) related to a specific individual. This service cannot be substituted for supervision or intervention with individuals.

Key service functions include, but are not limited to:

- An assessment of the individual's presenting condition as reported by staff
- Review of the treatment plan through consultation
- Individual-specific consultation with staff especially in situations which pose high risk of psychiatric decompensation, hospitalization, or safety issues
- Individual-specific recommendations regarding high risk issues and, when needed, to promote early intervention

Limitations for Physician and Professional Consultation

Consultation services are limited to two (2) hours, eight (8) units per day, per individual. This service is only covered when provided by a physician/physician extender.

Consultation services are not billed for the time the prescriber spends in the daily team meetings reviewing individual status with the other team members. Those costs are built into the daily team rate. This procedure code should be used for individual case consultation that occurs outside of the team meeting.

Physician time is included in the rates for intake evaluation, annual evaluation/assessment and treatment planning. Physician consultation should not be billed in conjunction with H0031, H0031 GT, H0031 52, H0031 52 GT, H0002, H0002 GT, H0032 or H0032 GT.

When the assertive community treatment (ACT)/ACT transition age youth (TAY) team prescriber provides a substantial consultation service (meeting the 15 minute unit requirement), the service is billed separately from the ACT team rate, using the appropriate procedure code for the prescriber type.

Documentation Requirements for Physician and Professional Consultation

Documentation requirements for physician and professional consultation are specified in [Section 2.3](#) of this manual. Procedure codes 99202-99205 and 99211-99215 should be utilized for these services and can be referenced in [Section 5](#) of this manual.

2.10.N Integrated Treatment for Co-Occurring Disorders

Integrated Treatment for Co-Occurring Disorders (ITCD) is integrating substance use disorder treatment with CPR for individuals with co-occurring psychiatric and SUDs. ITCD is a practice based on evidence and research for individuals with serious mental illness and SUDs.

Individuals who meet criteria for ITCD must meet admission criteria as defined in [9 CSR 30-4.005](#) and must have a co-occurring SUD. Individuals shall receive screening for both mental health and SUDs. If individuals present with both mental health and substance use identified service needs, they shall receive an integrated assessment identifying service needs as well as stage of readiness for change.

ITCD shall be delivered by a multidisciplinary team responsible for coordinating a comprehensive array of services available to the individual through CPR with the amount and frequency of service commensurate with the individual's assessed need. The multidisciplinary team shall include, but is not limited to, the following:

- Physician/physician extender
- RN
- QMHP
- Additional staff sufficient to provide community support and retain the responsibility for acquisition of appropriate housing and employment services
- A qualified co-occurring disorders specialist defined as a person who demonstrates substantial knowledge and skill regarding SUDs by being one (1) of the following:
 - A physician or QMHP in Missouri or an individual who meets the applicable training and credentialing required by the Missouri Credentialing Board for any of the following accreditations as a QAP:
 - Certified Alcohol and Drug Counselor (CADC)
 - Certified Reciprocal Alcohol and Drug Counselor (CRADC)
 - Certified Reciprocal Advanced Alcohol and Drug Counselor (CRAADC)
 - Certified Criminal Justice Addictions Professional (CCJP)
 - Registered Alcohol Drug Counselor-Provisional (RADC-P)
 - Registered Alcohol Drug Counselor (RADC)
 - Co-Occurring Disorders Professional (CCDP)
 - Co-Occurring Disorders Professional-Diplomat (CCDP-D)
 - The QMHP or QAP must also have one (1) year of training or supervised experience in SUD treatment. If they have less than one (1) year of experience in providing co-occurring disorder treatment, they shall be actively acquiring 24 hours of training in co-occurring disorders content and receive supervision from experienced co-occurring disorders staff as approved by DMH.

The multidisciplinary treatment team shall meet regularly to discuss each individual's progress and goals and provide insights and advice to one another. Multidisciplinary team members shall receive ongoing training in ITCD and have a training plan that addresses specific ITCD criteria, including co-occurring disorders, motivational interviewing, stage-wise treatment, cognitive behavioral interventions and SUD treatment.

The number of integrated treatment teams is determined by the needs and number of individuals being supported.

ITCD shall be delivered according to the ITCD model and criteria specified by DMH. Services are time unlimited with the intensity modified according to level of need and degree of recovery; include outreach efforts and interventions to promote physical health, especially related to substance use; and target specific services to individuals who do not respond to treatment.

In addition to eligible CPR services, ITCD services include co-occurring assessment supplement, co-occurring individual counseling, co-occurring group counseling, co-occurring group rehabilitative support and other services, as appropriate. The agency shall arrange for referrals for withdrawal management or hospitalization services when appropriate. The agency shall provide housing and vocational services consistent with the ITCD model.

Staff shall help individuals in the engagement and persuasion stages recognize the consequences of their substance use, resolve ambivalence related to their addiction, and introduce them to self-help principles. Individuals in the active treatment or relapse prevention stage shall receive co-occurring individual and/or group counseling and be assisted in connecting with self-help programs in the community. Families and other natural supports shall receive education and, as appropriate, be involved in counseling.

An integrated treatment plan shall be developed by the multi-disciplinary team, including input from the qualified co-occurring disorders specialist (may be referred to as the integrated treatment specialist), and shall include participation of the individual receiving services. The treatment plan shall address mental health and substance use disorder treatment strategies that involve building both skills and supports for recovery.

Interventions shall be consistent with, and determined by, the individual's identified stage of treatment.

Co-Occurring Assessment Supplement

Individuals who present with both substance use and mental health identified service needs must receive additional assessments to document the co-occurring disorders and assess the interaction of the co-occurring disorders over time. The co-occurring assessment is documented as required by DMH, along with the development of an integrated treatment plan developed by the multi-disciplinary team, including input from the qualified co-occurring disorders specialist, and shall include participation of the individual receiving services. The treatment plan shall address mental health and SUD treatment strategies that involve building both skills and supports for recovery. Interventions shall be consistent with, and determined by, the individual's identified stage of treatment.

Eligible providers include a QMHP, an individual holding the Co-Occurring Disorders Professional or Co-Occurring Disorders Professional Diplomate credential, a non-licensed QMHP or a QAP who meets the co-occurring counselor competency requirements established by DMH.

Limitations for the Co-Occurring Assessment Supplement

The co-occurring assessment supplement is limited to one (1) per treatment episode. The annual assessment should be updated as specified in [Section 2.10.B](#) of this manual.

Documentation Requirements for the Co-Occurring Assessment Supplement

Documentation requirements for the co-occurring assessment supplement are specified in [Section](#)

[2.3](#) of this manual.

Procedure Code	Description
H0031 HH	Co-Occurring Assessment Supplement

Co-Occurring Individual Counseling

The co-occurring individual counseling service is a structured, goal-oriented therapeutic process in which an individual, interacts with a qualified provider in accordance with the individual's treatment plan to resolve problems related to their documented mental health and SUD that interferes with their functioning.

Co-occurring individual counseling involves the use of evidence-based practices such as motivational interviewing, cognitive behavior therapy, harm reduction and relapse prevention.

Co-occurring individual counseling may include interaction with one (1) or more members of the individual's family or other natural supports for the purpose of assessment or supporting the individual's recovery.

Eligible providers must be a QMHP or QAP and meet co-occurring counselor competency requirements established by DMH.

Limitations for Co-Occurring Individual Counseling

Co-occurring individual counseling services are limited to three (3) hours, 12 units per day, per individual.

Documentation Requirements for Co-Occurring Individual Counseling

Documentation requirements for co-occurring individual counseling are specified in [Section 2.3](#) of this manual.

Procedure Code	Description
H0004 HH	Co-Occurring Individual Counseling

Co-Occurring Group Counseling

Co-occurring group counseling is goal-oriented, therapeutic interaction between a counselor and two (2) or more individuals as specified in individual treatment plans, designed to promote individual self-understanding, self-esteem, and resolution of personal problems related to the individual's documented mental disorders and substance use disorders through personal disclosure and interpersonal interaction among group members. This service utilizes evidence-based practices.

Eligible providers include a QMHP, an individual holding the Co-Occurring Disorders Professional or Co-Occurring Disorders Professional Diplomate credential, a non-licensed QMHP or a QAP who meets the co-occurring counselor competency requirements established by DMH.

Limitations for Co-Occurring Group Counseling

Group size for co-occurring group counseling shall not exceed 10 individuals. Co-occurring group counseling services are limited to three (3) hours, 12 units per day, per individual.

Documentation Requirements for Co-Occurring Group Counseling

Documentation requirements for co-occurring group counseling are specified in [Section 2.3](#) of this manual.

Procedure Code	Description
H0005 HH	Co-Occurring Group Counseling

Co-Occurring Group Rehabilitative Support

Co-occurring group rehabilitative support is informational and experiential services designed to assist individuals, family members and others identified by the individual as a primary natural support, in the management of substance use and mental health disorders. Services are delivered through systematic, structured, didactic methods to increase knowledge of mental illnesses and SUDs. This includes integrating affective and cognitive aspects in order to enable the individuals, as well as family members/natural supports, to cope with the illness and understand the importance of their individual plan of care. The primary goal is to restore lost functioning and promote reintegration and recovery through knowledge of one's disease, symptoms and precursors to crisis, crisis prevention planning, community resources, recovery management and medication action, interaction and side effects.

Co-occurring group rehabilitative support focuses on evidence-based practices such as promotion of participation in peer self-help, brain chemistry and functioning, the latest research on illness causes and treatments, medication education and management, symptom management, behavior management, stress management, improving daily living skills and independent living skills.

Limitations for Co-Occurring Group Rehabilitative Support

Co-occurring group rehabilitative support group size is limited to 20 individuals. Eligible providers must have documented education and experience related to the topic presented and either be or be supervised by a QMHP or a QAP who meets co-occurring counselor competency requirements established by DMH.

Co-occurring group rehabilitative support services are limited to three (3) hours 12 units per day, per individual.

Documentation Requirements for Co-Occurring Group Rehabilitative Support

Documentation requirements for co-occurring group rehabilitative support are specified in [Section 2.3](#) of this manual.

Procedure Code	Description
H0025 HH	Co-Occurring Group Rehabilitative Support

2.10.O Day Treatment for Children/Youth

Day Treatment for Youth is an intensive array of services provided in a structured, supervised environment designed to reduce symptoms of a psychiatric disorder and maximize the individual's functioning so they can attend school and interact in their community and family setting.

Services are individualized based on the individual's needs and include a multidisciplinary approach to care under the direction of a physician. The integrated treatment milieu combines counseling and family interventions. These goal oriented therapeutic activities provide for the diagnostic and treatment stabilization of acute or chronic symptoms which have resulted in functional deficits that interfere significantly with daily functioning and requirements.

It is vital that the parents/guardians be actively involved in the services if the individual is to receive the full benefit of the service. Services may be provided to the individual's family and significant others when such services are for the direct benefit of the individual, in accordance with their needs and treatment goals identified in the treatment plan and for assisting in the individual's recovery.

The provision of educational services shall be in compliance with Individuals with Disabilities Education Act and section **167.126, RSMo**. Services shall be provided in the following manner:

- Hours of operation shall be based on program capacity, staffing availability, space requirements and as specified by the department.
- Eligibility criteria includes:
 - For children six (6) years of age or older, the child must be at risk of inpatient or residential placement as a result of a SED.
 - For children five (5) years of age or younger, the child must exhibit one or more of the following:
 - Has been expelled from multiple day care/early learning programs due to emotional or behavioral dysregulation in relation to SED or diagnosis based on the most recent edition of the Diagnostic Classification of Mental Health and Development Disorders of Infancy and Early Childhood (DC:0-5™)
 - Is at risk for placement in an acute psychiatric hospital or residential treatment center as a result of a SED
 - Has a score in the seriously impaired functioning level on the standardized functional tools approved by DMH for this age range
- Key service functions include, but are not limited to, the following:
 - Providing integrated treatment combining education, counseling and family interventions
 - Promoting active involvement of the parent/guardian in the program
 - Consulting and coordinating with the child/family's private service providers, as applicable, to establish and maintain continuity of care
 - Coordinating and sharing information with the child's school, including discharge planning, consistent with Family Educational Rights and Privacy Act and Health Insurance Portability and Accountability Act (HIPAA)

- Requesting screening and assessment reports from the child's school to determine any special education needs
- Planning the individualized educational needs of the child with their school
- Providing other core services as prescribed by the department

For programs serving children three (3) to five (5) years of age, services must be provided by a team of at least one (1) QMHP and one (1) appropriately certified, licensed, or credentialed ancillary staff.

For programs serving school-age children, services must be provided by a team consisting of at least one (1) QMHP and two (2) appropriately certified, licensed, or credentialed ancillary staff. Ancillary staff includes:

- Occupational therapists
- Physical therapists
- Assistant behavior analysts
- Individuals with a bachelor's degree in child development, psychology, social work or education
- Individuals with an associate's degree, or two (2) years of college, and two (2) years of experience in a mental health or child-related field
- Individuals meeting the qualifications for community support specialist (see [Section 2.5](#) of this manual) with at least three (3) years of population-specific experience providing community support services in accordance with the key service functions for this service as specified in [section 2.10.H](#) of this manual

Limitations for Day Treatment for Children/Youth

Expectations for a youth's minimum attendance in a day treatment service or program shall be determined by the interdisciplinary treatment team and documented in the youth's treatment plan. In this manner, the day treatment service shall be individualized to meet the clinical needs of each youth, and providers are allowed maximum flexibility as they attempt to keep youth engaged in this valuable treatment option.

The provider may bill for less than the individualized minimum attendance requirement for the following:

- Youth illness (including mental health emergencies that may require stabilization)
- Building/school closures (weather related emergencies, public health emergencies, school holidays)
- Family emergencies

Documentation Requirements for Day Treatment for Children/Youth

Minimum daily note for billing to day treatment and providers will follow requirements for fee for service Medicaid (e.g. therapy.)

Documentation in the clinical record must reflect the reason(s) for less than minimum attendance as indicated on the child's treatment plan.

Documentation must also include relevant information reported by family members/natural supports regarding a change in the child's condition or an unusual or unexpected occurrence in their life.

Proceure Code	Description
H2012 HA	Day Treatment

2.10.P Family Support

Family Support services are designed to provide a support system for parents/caregivers of an individual 25 years of age and younger who have a SED. Activities are directed and authorized by the child/youth's treatment plan. Key service functions include, but are not limited to:

- Providing information and support to the parent/caregiver so they have a better understanding of their child/youth's needs and options to be considered as part of their treatment
- Assisting the parent/caregiver in understanding the planning process and the importance of their voice in the development and implementation of the individualized treatment plan
- Providing support to empower the parents/caregivers to be a voice for their child/youth and family in the planning meeting
- Working with the family to highlight the importance of individualized planning and the strengths-based approach
- Assisting the family in understanding the roles of the various providers and the importance of the team approach
- Discussing the benefits of natural supports within their family and community
- Introducing methods for problem solving and developing strategies to address issues that need attention
- Providing support and information to parents/caregivers to shift from being the decision maker to the support person as the child/youth becomes more independent
- Connecting families to community resources
- Empowering parents/caregivers/youth to become involved in activities related to planning, developing, implementing, and evaluating programs and services
- Connecting parent's, caregivers, children/youth to others with similar lived experiences to increase their support system

The eligible provider must be a family member of a child or youth who had or currently has a behavioral or emotional disorder. The family member must have a high school diploma or equivalent certificate, be credentialed by the Missouri Credentialing Board, and be supervised by a QMHP or QAP.

The specific skills and activities that are the focus of this intervention will be identified on the child's treatment plan and are developmentally appropriate. Collateral contact (e.g. phone calls with

Children’s Division (CD), schools, etc.) may be billed. Travel time required for making contact with individuals, families and other agencies may be billed.

Limitations for Family Support

Family Support services are limited to eight (8) hours (32 units) per day and 24 hours (96 units) per month, per individual. Family Support can be billed for transportation to and from an appropriate service activity. Family Support cannot be billed if the only service being provided is transportation.

Documentation Requirements for Family Support

Documentation requirements for Family Support services are specified in [Section 2.3](#) of this manual.

Procedure Code	Description
H0038 HA	Family Support

2.10.Q Family Assistance

Family Assistance services focus on development of home and community living skills and communication and socialization skills for children and youth, including coordination of community-based services. Key service functions include, but are not limited to:

- Modeling appropriate behaviors and coping skills for the child
- Exposing the child to activities that encourage positive choices, promote self-esteem, support academic achievement and develop problem solving skills for home and school
- Teaching appropriate social skills through hands-on experiences
- Mentoring appropriate social interactions with the child or resolving conflict with peers

The specific skills and activities that are the focus of this intervention will be identified on the child’s treatment plan and are developmentally appropriate. Collateral contact (e.g. phone calls with the CD, schools, etc.) may be billed.

The eligible provider must be an individual with a high school diploma or equivalent and two (2) years of experience working with children who have a SED or have experienced abuse and neglect. Staff must also be credentialed by the Missouri Credentialing Board and be supervised by a QMHP or QAP.

Limitations for Family Assistance

Family Assistance services are limited to eight (8) hours (32 units) per day and 24 hours (96 units) per month, per individual. Family Assistance cannot be billed if the only service being provided is transportation.

Documentation Requirements for Family Assistance

Documentation requirements for family assistance services are specified in [Section 2.3](#) of this manual.

Procedure Code	Description
H2014 HA	Family Assistance

2.10.R Assertive Community Treatment

Assertive Community Treatment (ACT) is a transdisciplinary team model used to deliver comprehensive and flexible treatment, support and services to adults or transition age youth (ages 16 to 25) who have the most severe symptoms of a serious mental illness or SED and who have the greatest difficulty with basic daily activities. Adults or transition age youth who receive ACT services typically have needs that have not been effectively addressed by traditional, less intensive behavioral health services.

Individuals shall have at least one (1) of the diagnoses as specified by DMH, meet one (1) or more of the conditions specified in [9 CSR 30-4.0432\(7\)](#), and meet all other CPR admission criteria as defined in [9 CSR 30-4.005](#). The diagnosis may coexist with other psychiatric diagnoses. For adults or transition age youth exhibiting extraordinary clinical needs, the team may apply to DMH to approve admission to ACT services.

Individuals must meet one (1) or more of the following conditions to receive ACT services:

- Recent discharge from an extended stay of three (3) months or more in a state hospital for an adult or an extended stay in a residential facility for transition age youth
- High utilization of two (2) admissions or more per year in an acute psychiatric hospital and/or six (6) or more per year for psychiatric emergency services
- Have a co-occurring SUD greater than six (6) months duration
- Exhibit socially disruptive behavior with high risk of involvement in the justice system including arrest and incarceration
- Reside in substandard housing, is homeless, or at imminent risk of becoming homeless
- Experience the symptoms of an initial episode of psychosis within the past two (2) years (hallucinations, delusions or false beliefs, confused thinking or other cognitive difficulties) leading to a significant decrease in overall functioning
- Other indications demonstrating that the adult or transition age youth has difficulty thriving in the community

These requirements apply to all ACT teams, including specialized teams for women and children, transition age youth, transition age youth with behavioral health and developmental disabilities, transition age youth with co-occurring disorders and forensic ACT.

ACT shall be delivered by a transdisciplinary team responsible for coordinating a comprehensive array of services. Unless specified otherwise, the team shall meet face-to-face at least five (5) times per week to review the status of each individual. The team shall include, but is not limited to, the following disciplines:

- Have adequate prescribing capacity by meeting one (1) of the following:
 - A physician/physician extender who shall be available 16 hours per week to no more than 50 individuals to assure adequate direct psychiatric treatment

- A combination of a physician/physician extender equaling 16 hours per week shall be available to no more than 50 individuals
- In a service area designated as a Mental Health Professional Shortage Area, the psychiatrist, physician assistant, psychiatric pharmacist, assistant physician or psychiatric resident shall be available 10 hours per week to no more than 50 individuals; or an APRN shall be available 16 hours per week to no more than 50 individuals; two (2) prescribers working on the same team must include each prescriber working a minimum of eight (8) hours per week
- The ACT team prescriber shall attend at least two (2) team meetings per week either face-to-face or by teleconference.
- A registered nurse with six (6) months of psychiatric nursing experience who shall work with no more than 50 individuals on a full-time basis.
- A team leader who is a QMHP that is full time on the team with one (1) year of supervisory experience and a minimum of two (2) years experience working with adults and/or transition age youth with a serious mental illness or SED in community settings.
- A qualified co-occurring disorder specialist by being one (1) of the following:
 - A physician or QMHP in Missouri or a QAP) who meets the applicable training and credentialing required by the Missouri Credentialing Board with any of the following:
 - Certified Alcohol and Drug Counselor (CADC)
 - Certified Reciprocal Alcohol and Drug Counselor (CRADC)
 - Certified Reciprocal Advanced Alcohol and Drug Counselor (CRAADC)
 - Certified Criminal Justice Addictions Professional (CCJP)
 - Registered Alcohol Drug Counselor-Provisional (RADC-P)
 - Registered Alcohol Drug Counselor (RADC)
 - Co-Occurring Disorders Professional (CCDP)
 - Co-Occurring Disorders Professional-Diplomat (CCDP-D)
 - The QMHP or QAP shall also have one (1) year of training or supervised experience in SUD treatment. If they have less than one (1) year of experience in providing co-occurring disorder treatment, they shall be actively acquiring 24 hours of training in co-occurring disorders content and receive supervision from experienced co-occurring disorders staff as approved by DMH.
- Have adequate employment and education specialization capacity by meeting one (1) of the following:
 - An employment and education specialist who qualifies as a CSS with one (1) year of experience and training in supported employment shall be available to no more than 50 individuals
 - If the employment and education specialist is not assigned to a team full-time or is assigned to a team with less than 50 individuals, the employment and education specialist shall attend at least two (2) team meetings per week

- Include a peer specialist who is self-identified as currently or formerly receiving mental health services; is assigned full-time to a team and participates in the clinical responsibilities and functions of the team in providing direct services; and serves as a model, a support and a resource for the team members and individuals being served. Peer specialists, at a minimum, shall meet the qualifications of a Certified Peer Specialist.
- Include a program assistant who has education and experience in human services or office management. The program assistant shall organize, coordinate and monitor all non-clinical operations of the team including, but not limited to, the following:
 - Managing medical records
 - Operating and coordinating the management information system
 - Triaging telephone calls and coordinating communication between the team and individuals receiving ACT services
- Other team members may be assigned to work exclusively with the team and must qualify as a CSS or a QMHP.

At the admission meeting, team members shall introduce themselves and explain the ACT program. When the individual decides to accept ACT services, the team shall immediately open a record and schedule initial service contacts with the individual for the next few days. A comprehensive assessment shall be completed on the day of admission. The comprehensive assessment shall be based on information obtained from the individual, referring treatment provider, and family/natural supports or other supporters who participate in the admission process and shall include, but not be limited to, the following:

- The individual's mental and functional status
- The effectiveness of past treatment
- The current treatment, rehabilitation and support service needs

The initial treatment plan shall be completed on the day of admission including initial needs and interventions, be used to support recovery and be used by the team as a guide until the comprehensive assessment and treatment plan are completed. The team shall ensure the individual receiving services participates in the development of the initial treatment plan.

The team's physician/physician extender shall approve the treatment plan. A licensed psychologist, as a team member, may approve the treatment plan only when the individual is currently receiving no prescribed psychiatric medications to treat a mental health condition and the clinical recommendations do not include a need for prescribed psychiatric medications for a mental health condition.

To be in compliance with DMH regulations, the team shall follow a systematic process including admission, comprehensive and ongoing assessment and continuous treatment planning utilizing the assessment and treatment planning protocol and components included in the internationally recognized Tool for Measurement of Assertive Community Treatment (TMACT) and in the fidelity protocol specified by DMH.

The team shall conduct the comprehensive ACT assessment as they are working with the individual in the community delivering services outlined in the initial treatment plan. The comprehensive ACT assessment provides a guide for the team to collect information including the individual's history, including trauma history, past treatment and to become acquainted with the individual and their family members. This assessment enables the team to individualize and tailor ACT services to ensure courteous, helpful and respectful treatment. The comprehensive assessment includes, but is not limited to:

- Psychiatric history, mental status, and diagnosis
- Physical health
- Use of drugs and/or alcohol
- Education and employment
- Social development and functioning
- Activities of daily living
- Family structure and relationships
- Functional assessment approved by DMH for individuals whose diagnosis requires a functional score to support admission

Team members, with supervision from the team leader, shall complete their respective sections of the comprehensive assessment within 30 days of admission. The assessment is ongoing throughout the course of ACT treatment and consists of information and understanding obtained through day-to-day interactions with the individual, the team and others, such as landlords, employers, family, friends and others in the community. The comprehensive assessment is a daily and ongoing process that is continuously updated and documented as information changes or is received.

Comprehensive treatment plans shall be developed within 45 days of admission utilizing information obtained from the comprehensive assessment and contain objective goals based on the individual's preferences and shall be person-specific. The plan shall contain specific interventions and services that will be provided, by whom, for what duration and location of the service. The treatment plan shall be revised or re-written every six (6) months.

ACT services shall be delivered seven (7) days per week, including evenings and holidays based upon individual needs. At least two (2) hours of direct ACT services shall be available on each day of the weekend and on holidays. A team member shall be on call 24 hours per day, seven (7) days per week. The team shall be available to individuals on an ACT team who are in crisis 24 hours a day, seven (7) days a week. The team is the first-line crisis evaluator and responder. If another crisis responder screens calls, there is minimal triage. When the team is contacted, the team shall determine the need for team intervention and whether that intervention be by telephone or face-to-face, with back-up by the team leader and ACT team prescriber. Individualized, practical crisis prevention plans shall be available to staff who are on call.

The team shall provide goal-driven services for all individuals enrolled in ACT including, but not limited to:

- Psychopharmacologic treatment

- Nursing
- Integrated treatment for co-occurring disorders
- Supported employment and education
- Peer support
- Crisis intervention
- Psychiatric rehabilitation and skills training to improve functioning
- Wellness management and recovery
- Empirically supported psychotherapy
- Supportive housing

Individuals who are experiencing severe, emergent or acute symptoms shall be contacted multiple times daily by the team. At a minimum, 75% of team contacts shall occur out of the office. Individuals shall have direct contact with more than two (2) team members per month.

Individuals with co-occurring disorders shall be provided integrated mental health and SUD treatment.

The team shall conduct regular assessment of the need for ACT services and use explicit criteria or markers for the need to transfer to a less intensive service option. Transition shall be gradual and individualized, with assured continuity of care with regular monitoring of the individual's status following transition based on individual need. There shall be an option to return to the team, as needed.

A transition plan shall be developed incorporating graduated step down in intensity and including overlapping team meetings as needed to facilitate the transition of the individual. The individual shall be engaged in the next step of treatment and rehabilitation.

Documentation of transition to less intensive services shall include a systematic plan to maintain continuity of treatment at appropriate levels of intensity to support the individual's continued recovery and have easy access to return to the ACT team if needed. A discharge summary shall include, but is not limited to:

- Dates of admission and transition to less intensive services
- Reason for admission and referral source
- Diagnosis or diagnostic impression
- Description of services provided and outcomes achieved, including any prescribed medication, dosage and response
- Reason for or type of transition or discharge from the team
- Medical status and needs that may require ongoing monitoring and support

An aftercare plan shall be completed prior to transition to less intensive services or discharge from the team. The plan shall identify services, designated provider(s) or other planned activities designed to promote further recovery.

The ACT team shall update the treatment plan or DMH-approved functional assessment (if applicable) every 90 days to assess individual functioning, progress toward treatment objectives and

appropriateness of continued services. Documentation in the individual record shall include, but is not limited to:

- Barriers, issues, or problems identified by the individual, family, guardian and/or team that identify the need for focused services
- A brief explanation of any change or progress in the daily living functional abilities in the prior 90 days
- A description of the changes for the plan of treatment based on information obtained from the functional assessment

The ACT program also shall include other information in the individual record, if not otherwise addressed in the intake/annual evaluation or treatment plan, including:

- The individual's medical history, including:
 - Medical screening or relevant results of physical examinations
 - Diagnosis, physical disorders and therapeutic orders
- Evidence of informed consent
- Results of prior treatment
- Condition at discharge from prior treatment

Any authorized person making any entry in an individual's record shall sign and date the entry, including corrections to information previously entered in the individual's record.

Limitations for Assertive Community Treatment

ACT services for adults or transition age youth are billed once per day on any day in which the individual receives a direct intervention in person or by phone from a team member, excluding medication management, consultation and group services by physician/physician extender.

ACT services may also be billed when a team member makes contact with families, natural supports or other agencies on behalf of the individual.

Medication management services provided by a physician/physician extender cannot be billed to the daily ACT team rate. Those services are billed as Medication Services as described in 2.10.E of this manual.

Consultation services provided by a physician/physician extender cannot be billed to the daily ACT team rate. Those services are billed as Consultation Services as described in [section 2.10.M](#) of this manual.

Services provided to the parent/guardian by the certified family support provider may only be billed to the ACT team daily rate for transition age youth.

Intake and Annual Evaluation procedure codes (H0031, H0031 GT, H0031 52, H0031 52 GT) may not be billed while the individual is enrolled in ACT.

Evaluation, assessment and treatment planning activities provided by team members are billed using the daily team rate.

The ACT procedure codes H0040 and H0040 HA may only be billed once per day, per individual; if an individual receives multiple direct contacts in a day from non-medical team members, the procedure code is only billed once.

Documentation Requirements for Assertive Community Treatment

Documentation requirements for ACT are specified in [Section 2.3](#) of this manual.

All direct services which result in the billing of the daily team rate must be documented in the individual's clinical record and be easily accessible to team members.

In addition to documentation specified for medication services, the ACT provider shall provide additional documentation for each service episode, unit or as clinically indicated, for each service provided to the individual as follows:

- Description of the individual's presenting condition
- Pertinent medical and psychiatric findings
- Observations and conclusions
- Individual's response to medication, including identifying and tracking over time one (1) or more target symptoms for each medication prescribed
- Actions and recommendations regarding the individual's ongoing medication regimen
- Pertinent/significant information reported by family members, natural supports or significant others regarding a change in the individual's condition, an unusual or unexpected occurrence in the individual's life, or both

Procedure Code	Description
H0040	Assertive Community Treatment (ACT)
H0040 HA	Assertive Community Treatment Transitional Age Youth

2.10.S Act Group Psychosocial Rehabilitation Services

Group Psychosocial Rehabilitation Services is a focused group providing illness management and recovery services that promote physical and mental wellness, well-being, self-direction, personal empowerment, respect and responsibility in group settings. Services shall be person centered and strength based and include, but it not limited to group rehabilitative support, relapse prevention and coping skills training.

Limitations for Act Group Psychosocial Rehabilitation Services

Group psychosocial rehabilitation is limited to eight (8) individuals per group and no more than 40 units per day.

Documentation Requirements for Act Group Psychosocial Rehabilitation Services

Documentation requirements for Group Psychosocial Rehabilitation Services are specified in [Section 2.3](#) of this manual.

Procedure Code	Description
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H2017 TG HK	Group Psychosocial rehabilitation services (Physician ACT)
H2017 TG GC	Group Psychosocial rehabilitation services (Resident ACT)
H2017 TG SA	Group Psychosocial rehab. services (APRN ACT)
H2017 TG HE	Group Psychosocial rehab. services (Psychiatric Pharmacist ACT)
H2017 TG AF	Group Psychosocial rehab. services (Child Psychiatrist ACT)
H2017 TG AR	Group Psychosocial rehab. services (Physician Assistant ACT)

2.10.T Act Group Psychotherapy

Goal oriented treatment designed to maximize strengths and to reduce behavior problems and/or functional deficits stemming from the existence of a mental disorder that interferes with a individual's personal, familial, vocational and/or community adjustment.

Limitations for Act Group Psychotherapy

Group Psychotherapy is limited to eight (8) individuals per group and no more than 12 units per day.

Documentation Requirements for Act Group Psychotherapy

Documentation requirements for Group Psychotherapy are specified in [Section 2.3](#) of this manual.

Procedure Code	Description
H0004 HQ	Group Psychotherapy (Physician ACT)
H0004 HQ GC	Group Psychotherapy (Resident ACT)
H0004 SA HQ	Group Psychotherapy (APN ACT)
H0004 HQ HE	Group Psycholtherapy (Psychiatric Pharmacist ACT)
H0004 HQ AF	Group Psycholtherapy (Child Psychiatrist ACT)
H0004 HQ AR	Group Psychotherapy (Physician Assistant ACT)

2.10.U School-Based Services

School-based services provide for an expansion of availability and accessibility of treatment services through the delivery of designated CPR services in school settings by the administrative agents in the region. Designated CPR services are provided to children with an Individualized Education Plan (IEP), as well as those without an IEP. The services described in this manual and billed to DMH are for non-IEP services only.

Documentation Requirements for School-Based Services

Documentation requirements for school-based services are specified in [Section 2.3](#) of this manual.

Procedure Code	Description
H0002	Behavioral Health Assessment
H0031 52	Comprehensive Annual Evaluation/Treatment Plan
H0031 52 GT	Comprehensive Annual Evaluation/Treatment Plan (Telehealth)
H0031	Comprehensive Annual Evaluation/Treatment Plan
H0031 GT	Comprehensive Annual Evaluation/Treatment Plan (Telehealth)

H0032	Treatment Planning
H0032 GT	Treatment Planning (Telehealth)
H0036	Community Support
H0037	Intensive CPR
H0037 HA	Intensive Evidence Based Practice
H0038 HA	Family Support
H2011	Crisis Intervention
H2014 HA	Family Assistance
H2017 HA	PSR - Youth
H0004 HH	Co-Occurring Individual Counseling
H0005 HH	Co-Occurring Group Counseling
H0025 HH	Co-Occurring Group Rehabilitative Support
H0031 HH	Co-Occurring Assessment Supplement
H0040	ACT Team
H0040 HA	ACT TAY
H2017 HO	Individual Professional PSR
H2017 HQ HO	Group Professional PSR
H2012 HA	Day Treatment – Youth

2.11 Laboratory Services

Laboratory services are not covered through the CPR Program. Laboratory services may be reimbursable to other appropriate MO HealthNet enrolled provider types subject to program limitations.

2.12 Prescription Drugs

Prescription drugs are not covered through the CPR Program. Refer to the Pharmacy manual for more information.

2.13 Administrative Lock-In

Some MO HealthNet participants are restricted or "locked in" to authorized MO HealthNet providers of certain services to aid the participant in proper utilization of the MO HealthNet Program. Refer to the [General Sections Manual](#) for additional information about the program and information on identifying lock-in participants.

2.14 Quality Assurance

All CPR providers are monitored to assure compliance and quality of care by the Missouri DMH.

Section 3: Billing Instructions

3.1 Claim Submission

For all Community Psychiatric Rehabilitation (CPR) services, the provider submits all billing to the Missouri Department of Mental Health (DMH) through the web based Customer Information

Management Outcomes and Reporting system (CIMOR). DMH in turn submits eligible claims to the MO HealthNet Division (MHD.)

DMH submits services for the provider electronically using the most current required X12N version.

Providers may submit services electronically to CIMOR via a HIPAA 837 or through keying services directly online to CIMOR. Providers who wish to submit services electronically should refer to the HIPAA 837 Companion Guide, 835 Companion Guide, Batch Test Steps and Checklist and the Batch Submission Contacts List available at the [DMH website](#). Providers submitting CPR services electronically to CIMOR will receive a Remittance Advice from DMH.

Medicaid eligibility and claims submitted to MHD may be viewed in CIMOR. Providers may also use [eMOMED](#) to view eligibility. Refer to the [General Sections Manual](#) for additional information on eMOMED.

3.2 Resubmission of Claims

Providers may view their claims in CIMOR or may use the Remittance Advice if services were submitted to CIMOR electronically on a HIPAA 837.

Services that resulted in zero payment on a claim can be resubmitted if the claim denied due to a correctable error. The error that caused the claim to deny should be corrected before resubmitting it to MHD through CIMOR. The provider may use the Replace button on the service in CIMOR to resubmit a claim to MHD.

3.3 Inquiries

Providers may inquire about CPR services by requesting email support through the Division of Behavioral Health (DBH) Support Center. Email support is available after a successful login to the [DMH Portal Site](#) and selecting DBH Support Center on the subject line.

3.4 Community Psychiatric Rehabilitation Invoices

DMH generates CPR invoices through CIMOR after the remittance advice (835) is received from MHD. CIMOR invoices are available to providers and can be viewed online or printed.

3.5 Payments

After the MHD payments are generated, DMH accounting will generate invoice payments through CIMOR.

3.6 Insurance Coverage Codes

While providers are verifying the participant's eligibility, they can also obtain the Third Party Liability (TPL) information in CIMOR. Eligibility may be verified by accessing [eMOMED](#) or by calling the Interactive Voice Response (IVR) system at (573) 751-2896. Refer to the [General Sections Manual](#) for additional information.

Participants must always be asked if they have third party insurance regardless of the TPL information given by CIMOR, the IVR, or [eMOMED](#). It is the provider's responsibility to obtain from the participant the name and address of the insurance company, the policy number and the type of coverage. Refer to Section 5 of the [General Sections Manual](#) for additional information.

3.7 Community Psychiatric Rehabilitation Rebill Instructions

If a service on a claim was incorrect because the service was billed with incorrect information, (e.g., units are too high) the service should be adjusted in CIMOR and the claim will be resubmitted by DMH.

If a health insurance payment is received after the invoice has been paid, the amount collected must be credited back through CIMOR. The provider should make the adjustment in CIMOR and the claim will be resubmitted by DMH.

3.8 Special Billing Issues

For other special billing issues concerning CPR services, request email support through the DBH Support Center. Email support is available after a successful login to the [DMH Portal Site](#) and selecting DBH Support Center on the subject line.

Section 4: Diagnosis Codes

4.1 General Information

The diagnosis code is a required field when submitting a claim and the accuracy of the code that describes the participant's condition is important.

The diagnosis code must be entered on the claim form exactly as it appears in the current International Classification of Diseases (ICD) book. Note that the appropriate codes may be three to seven digits, depending upon the participant's diagnosis. For clinical purposes, most mental health providers use the Diagnostic and Statistical Manual of Mental Disorders (DSM-5), published by the American Psychiatric Association, as the standard diagnostic tool. However, when billing MO HealthNet, providers must use the ICD coding system.

The current ICD book should be used as a guide in the selection of the appropriate diagnosis code.

4.2 ICD-Clinical Modification Diagnosis Chart

The following chart lists the most common ICD10-Clinical Modification (CM) diagnosis codes.

Description	DSM-5 Code	ICD10-CM Code
Schizophrenia		
Disorganized	F20.9	F20.1
Catatonic	F20.9	F20.2
Paranoid	F20.9	F20.0

Schizophreniform	F20.9	F20.81
Residual	F20.9	F20.5
Schizoaffective	F20.9	F25.9
Undifferentiated	F20.9	F20.3
Unspecified	F20.9	F20.9
Delusional disorder	F22	F22
Description	DSM-5 Code	ICD10-CM Code
Bipolar I Disorders		
Manic episode without psychotic symptoms, unspecified	NA	F30.10
Manic episode without psychotic symptoms, mild	NA	F30.11
Manic episode without psychotic symptoms, moderate	NA	F30.12
Manic episode, severe, without psychotic symptoms	NA	F30.13
Manic episode, severe with psychotic symptoms	NA	F30.2
Manic episode in partial remission	NA	F30.3
Manic episode in full remission	NA	F30.4
Bipolar disorder, current episode hypomanic	F31.0	F31.0
Bipolar disorder, in partial remis, most recent ep hypomanic	F31.71	F31.71
Bipolar disorder, in full remis, most recent episode hypomanic	F31.72	F31.72
Bipolar disorder, current episode manic w/o psych features, unsp	F31.9	F31.10
Bipolar disorder, crnt episode manic w/o psych features, mild	F31.11	F31.11
Bipolar disorder, crnt episode manic w/o psych features, mod	F31.12	F31.12
Bipolar disorder, crnt episode manic w/o psych features, severe	F31.13	F31.13
Bipolar disorder, crnt epsd manic severew psych features	F31.2	F31.2
Bipolar disorder, in partial remis, most recent episode manic	F31.73	F31.73
Bipolar disorder, in full remis, most recent episode manic	F31.74	F31.74
Bipolar disorder, crnt epsd depress, mild or mod severt, unsp	F31.9	F31.30
Bipolar disorder, current episode depressed, mild	F31.31	F31.31
Bipolar disorder, current episode depressed, moderate	F31.32	F31.32
Bipolar disorder, crnt epsd depressed, sev, w/o psych features	F31.4	F31.4
Bipolar disorder, crnt epsd depress, sev, w psych features	F31.5	F31.5
Bipolar disorder, in partial remis, most recent epsd depress	F31.75	F31.75
Bipolar disorder, in full remis, most recent episode depress	F31.76	F31.76
Bipolar disorder, current episode mixed, unspecified	F31.9	F31.60
Bipolar disorder, current episode mixed, mild	F31.9	F31.61
Bipolar disorder, current episode mixed, moderate	F31.9	F31.62
Bipolar disorder, crnt epsd mixed, severe, w/o psych features	F31.9	F31.63
Bipolar disorder, crnt episode mixed, severe, w psych features	F31.9	F31.64
Bipolar disorder, in partial remis, most recent episode mixed	F31.9	F31.77
Bipolar disorder, in full remis, most recent episode mixed	F31.9	F31.78

Description	DSM-5 Code	ICD10-CM Code
Bipolar II Disorders	F31.81	F31.81
Description	DSM-5 Code	ICD10-CM Code
Unspecified Psychosis Not Due to a Substance or Known Physical Condition	F29	F29
Description	DSM-5 Code	ICD10-CM Code
Major Depressive Disorders		
Recurrent, Unspecified	F33.9	F33.9
Recurrent, mild	F33.0	F33.0
Recurrent, moderate	F33.1	F33.1
Recurrent, severe w/o psychotic features	F33.2	F33.2
Recurrent, severe with psychotic symptoms	F33.3	F33.3
Recurrent, in partial remission	F33.41	F33.41
Recurrent, in full remission	F33.42	F33.42
Description	DSM-5 Code	ICD10-CM Code
Obsessive-Compulsive Disorder		
Mixed Obsessional Thoughts and Acts	F42	F42.2
Obsessive-Compulsive Disorder, unspecified	F42	F42.9
Description	DSM-5 Code	ICD10-CM Code
Post Traumatic Stress Disorder	F43.10	F43.10, F43.12
Description	DSM-5 Code	ICD10-CM Code
Borderline Personality Disorder	F60.3	F60.3
Description	DSM-5 Code	ICD10-CM Code
Anxiety Disorders		
Generalized Anxiety Disorder	F41.1	F41.1
Agoraphobia, unspecified	F40.0	F40.0
Agoraphobia with Panic Disorder	F41.0	F40.01
Panic Disorder without Agoraphobia	F41.0	F41.0
Agoraphobia without Panic Disorder	F40.0	F40.02
Social Phobia	F40.10	F40.10
Description	DSM-5 Code	ICD10-CM Code
For Children and Youth Only		
Major Depressive Disorder		

Single episode, unspecified	F32.9	F32.9
Single episode, mild	F32.0	F32.0
Single episode, moderate	F32.1	F32.1
Single episode, Severe without Psychotic Features	F32.2	F32.2
Single episode, severe with psychotic features	F32.3	F32.3
Single episode, in partial remission	F32.4	F32.4
Single episode, in full remission	F32.5	F32.5
Bipolar disorder, Unspecified	F31.9	F31.9
Reactive attachment disorder of childhood	F94.1	F94.1
For Adults Aged 60 Years and Older		
Major Depressive Disorder		
Single episode, Unspecified	F32.9	F32.9
Single episode, Mild	F32.0	F32.0
Single episode, Moderate	F32.1	F32.1
Single episode, Severe without Psychotic Features	F32.2	F32.2
Single episode, Severe with Psychotic Features	F32.3	F32.3
Single episode, in partial remission	F32.4	F32.4
Single episode, in full remission	F32.5	F32.5
Depression, unspecified	F32.A	F32.9
Description	DSM-5 Code	ICD10-CM Code
Diagnostic Codes for All Persons for Eligibility with a Functional Assessment		
Bipolar Disorder, Unspecified	F31.9	F31.9
Disruptive Mood Dysregulation Disorder	F34.81	F34.81
Unspecified mood [affective] disorder	F34.81	F39
Shared Psychotic Disorder	F28	F24
Other Psych Disorder not Due to a Sub or Known Physiol Cond	F28	F28
Conversion Disorder with motor symptom or deficit	F44.4	F44.4
Conversion Disorder with seizures or convulsion	F44.5	F44.5
Conversion Disorder with sensory symptom or deficit	F44.6	F44.6
Conversion Disorder with mixed symptom presentation	F44.7	F44.7
Dissociative Identity Disorder	F44.81	F44.81
Dysthymic Disorder	F34.1	F34.1
Depersonalization-Derealization Syndrome	F48.1	F48.1
Body Dysmorphic Disorder	F45.22	F45.22
Hypochondriasis	F45.21	F45.21
Somatization Disorder	F45.1	F45.0
Undifferentiated Somatoform Disorder	F45.1	F45.1
Paranoid Personality Disorder	F60.0	F60.0
Cyclothymic Disorder	F34.0	F34.0
Schizoid Personality Disorder	F60.1	F60.1

Schizotypal Disorder	F21	F21
Obsessive-Compulsive Personality Disorder	F60.5	F60.5
Histrionic Personality Disorder	F60.4	F60.4
Dependent Personality Disorder	F60.7	F60.7
Antisocial Personality Disorder	F60.2	F60.2
Narcissistic Personality Disorder	F60.81	F60.81
Avoidant Personality Disorder	F60.6	F60.6
Personality Disorder, Unspecified	F60.9	F60.9
Pain Disorder exclusively related to Psychological Factors	F45.1	F45.41
Pain Disorder with related Psychological Factors	F45.1	F45.42
Intermittent Explosive Disorder	F63.81	F63.81
Unspecified Mood Disorder	NA	F39
Anxiety Disorder, Unspecified	F41.9	F41.9
Dissociative and Conversion Disorder, Unspecified	F44.9	F44.9
Major Depressive Disorder, single episode, Unspecified	F32.9	F32.9
Major Depressive Disorder, single episode, in partial remis	F32.4	F32.4
Description	DSM-5 Code	ICD10-CM Code
Additional Diagnostic Codes for Persons Age 6-25 for Eligibility with a Functional Assessment		
Separation Anxiety Disorder of Childhood	F93.0	F93.0
Oppositional Defiant Disorder	F91.3	F91.3
Impulse Disorder, Unspecified	F91.9	F63.9
Attention Deficit Disorder, Predominantly Inattentive Type	F90.0	F90.0
Attention Deficit Hyperactivity Disorder, Predominantly Hyperactive Type	F90.1	F90.1
Attention Deficit Hyperactivity Disorder, Unspecified type	F90.9	F90.9
Attention Deficit Hyperactivity Disorder, Combined Type	F90.2	F90.2
Other Conduct Disorders	F91.8	F91.8
Unspecified Disrupt, Impulsive Control & Conduct D/o	F91.9	F91.9

Section 5: Procedure Codes

Procedure codes used by the MO HealthNet Division (MHD) are identified as Health Care Procedure Coding System (HCPCS) codes. The HCPCS is divided into three subsystems, referred to as Level I, Level II and Level III. Level I is comprised of Current Procedural Terminology (CPT) codes that are used to identify medical services and procedures furnished by physicians and other health care professionals. Level II is comprised of the HCPCS National Level II codes that are used primarily to identify products, supplies and services not included in the CPT codes. Level III codes have been developed by Medicaid State agencies for use in specific programs.

5.1 Procedure Codes

Procedure Code	Description	Covered During Medical Inpatient Hospital Episode
H0002	Behavioral Health Assessment	YES
H0002 GT	Behavioral Health Assessment (Telemedicine)	YES
H0004 HH	Co-Occurring Individual Counseling	
H0004 HH GT	Co-Occurring Individual Counseling (Telemedicine)	
H0004 HQ	Group Psychotherapy-Physician (Assertive Community Treatment (ACT))	
H0004 HQ AF	Group Psychotherapy-Child Psychiatrist (ACT)	
H0004 HQ AR	Group Psychotherapy-Physician Assistant (ACT)	
H0004 HQ GC	Group Psychotherapy-Resident (ACT)	
H0004 HQ HE	Group Psychotherapy-Psychiatric Pharmacist (ACT)	
H0004 SA HQ	Group Psychotherapy-APN (ACT)	
H0005 HH	Co-Occurring Group Counseling	
H0005 HH GT	Co-Occurring Group Counseling (Telemedicine)	
H0025 HH	Co-Occurring Group Education	
H0025 HH GT	Co-Occurring Group Education (Telemedicine)	
H0031	Comprehensive Intake Evaluation/Treatment Plan	YES
H0031 GT	Comprehensive Intake Evaluation/Treatment Plan (Telemedicine)	YES
H0031 52	Comprehensive Annual Evaluation/Treatment Plan	YES
H0031 52 GT	Comprehensive Annual Evaluation/Treatment Plan (Telemedicine)	YES
H0031 HH	Co-Occurring Assessment Supplement	YES
H0031 HH GT	Co-Occurring Assessment Supplement (Telemedicine)	YES
H0032	Treatment Planning	YES
H0032 GT	Treatment Planning (Telemedicine)	YES
H0036	Community Support	YES
H0037	Intensive Community Psychiatric Rehabilitation	YES
H0037 GT	Intensive Community Psychiatric Rehabilitation (Telemedicine)	YES
H0037 HA	Evidence Based Practice	YES
H0037 HA GT	Evidence Based Practice (Telemedicine)	YES
H0037 HK	Intensive CPR Residential Clustered Apartments	
H0037 HK HA	Treatment Family Home	
H0037 TF	Intensive CPR Residential (Intensive Residential Treatment Setting (IRTS))	
H0037 TF HA	Professional Parent Home	

H0037 TG	Intensive CPR Residential (Psychiatric Individualized Support Living (PISL))	
H0037 TG HA	Children's Inpatient Diversion	
H0037 TG HB	Adult Inpatient Diversion	
H0038	Peer Support Services	YES
H0038 GT	Peer Support Services (Telemedicine)	YES
H0038 HA	Family Support	YES
H0038 HA GT	Family Support (Telemedicine)	YES
H0040	Assertive Community Treatment (ACT)	YES
H0040 GT	Assertive Community Treatment (ACT) (Telemedicine)	YES
H0040 HA	Assertive Community Treatment Transitional Age Youth (ACT Transition Aged Youth (TAY))	YES
H2010	Medication Administration	
H2010 GT	Medication Administration (Telemedicine)	
H2010 TD	Metabolic Syndrome Screening-Registered Nurse (RN)	
H2010 TD GT	Metabolic Syndrome Screening-RN (Telemedicine)	
H2010 TE	Metabolic Syndrome Screening-Licensed Practical Nurse (LPN)	
H2010 TE GT	Metabolic Syndrome Screening-LPN (Telemedicine)	
H2011	Crisis Intervention and Resolution	YES
H2012 HA	Day Treatment: Youth	
H2012 HA GT	Day Treatment: Youth (Telemedicine)	
H2014 HA	Family Assistance	YES
H2014 HA GT	Family Assistance (Telemedicine)	YES
H2017	Psychosocial Rehabilitation	
H2017 GT	Psychosocial Rehabilitation (Telemedicine)	
H2017 HA	Psychosocial Rehabilitation – Children and Youth	
H2017 HA GT	Psychosocial Rehabilitation – Children and Youth (Telemedicine)	
H2017 HO	Individual Professional Psychosocial Rehabilitation (PSR)	
H2017 HO GT	Individual Professional PSR (Telemedicine)	
H2017 HQ HO	Group Professional PSR	
H2017 TG	PSR Illness Management/Recovery	
H2017 TG GT	PSR Illness Management/Recovery (Telemedicine)	
H2017 TG AF	Group Psychoeducation-Child Psychiatrist (ACT)	
H2017 TG AR	Group Psychoeducation-Physician Assistant (ACT)	
H2017 TG GC	Group Psychoeducation-Resident (ACT)	
H2017 TG HE	Group Psychoeducation-Psychiatric Pharmacist (ACT)	
H2017 TG SA	Group Psychoeducation-Advanced Practice Nurse (APN) (ACT)	

90792	Psychiatric Diagnostic Evaluation-Physician	
90792 AF	Psychiatric Diagnostic Evaluation-Child Psychiatrist	
90792 GC	Psychiatric Diagnostic Evaluation, with medical services - Psychiatric Resident	
90792 GT	Psychiatric Diagnostic Evaluation-Physician, Telemedicine	
90792 GT AF	Psychiatric Diagnostic Evaluation-Child Psychiatrist, Telemedicine	
90792 HE	Psychiatric Diagnostic Evaluation-Psychiatric Pharmacist	
90792 HK	Psychiatric Diagnostic Evaluation-Physician (ACT)	
90792 HK GC	Psychiatric Diagnostic Evaluation, with medical services - Psychiatric Resident (ACT)	
90792 HK HE	Psychiatric Diagnostic Evaluation-Psychiatric Pharmacist (ACT)	
90792 SA	Psychiatric Diagnostic Evaluation-APN	
90792 SA GT	Psychiatric Diagnostic Evaluation-APN, Telemedicine	
90792 SA HK	Psychiatric Diagnostic Evaluation-APN (ACT)	
99202	Evaluation/Management – Physician/New Patient	
99203	Evaluation/Management – Physician/New Patient	
99204	Evaluation/Management – Physician/New Patient	
99205	Evaluation/Management – Physician/New Patient	
99212	Evaluation/Management – Physician/Established Patient	
99213	Evaluation/Management - Physician/Established Patient	
99214	Evaluation/Management – Physician/Established Patient	
99215	Evaluation/Management – Physician/Established Patient	
99202 AF	Evaluation/Management – Child Psychiatrist/New Patient	
99203 AF	Evaluation/Management – Child Psychiatrist/New Patient	
99204 AF	Evaluation/Management – Child Psychiatrist/New Patient	
99205 AF	Evaluation/Management – Child Psychiatrist/New Patient	
99212 AF	Evaluation/Management – Child Psychiatrist/Established Patient	
99213 AF	Evaluation/Management – Child Psychiatrist/Established Patient	

99214 AF	Evaluation/Management – Child Psychiatrist/Established Patient	
99215 AF	Evaluation/Management – Child Psychiatrist/Established Patient	
99202 AR	Evaluation/Management-Physician Assistant/New Patient	
99203 AR	Evaluation/Management-Physician Assistant/New Patient	
99204 AR	Evaluation/Management-Physician Assistant/New Patient	
99205 AR	Evaluation/Management-Physician Assistant/New Patient	
99212 AR	Evaluation/Management-Physician Assistant/Established Patient	
99213 AR	Evaluation/Management-Physician Assistant/Established Patient	
99214 AR	Evaluation/Management-Physician Assistant/Established Patient	
99215 AR	Evaluation/Management-Physician Assistant/Established Patient	
99202 GC	Evaluation/Management - Psychiatric Resident/New Patient	
99203 GC	Evaluation/Management - Psychiatric Resident/New Patient	
99204 GC	Evaluation/Management - Psychiatric Resident/New Patient	
99205 GC	Evaluation/Management - Psychiatric Resident/New Patient	
99212 GC	Evaluation/Management - Psychiatric Resident/Established Patient	
99213 GC	Evaluation/Management - Psychiatric Resident/Established Patient	
99214 GC	Evaluation/Management - Psychiatric Resident/Established Patient	
99215 GC	Evaluation/Management - Psychiatric Resident/Established Patient	
99202 GT	Evaluation/Management – Physician/New Patient, Telemedicine	
99203 GT	Evaluation/Management – Physician/New Patient, Telemedicine	
99204 GT	Evaluation/Management – Physician/New Patient, Telemedicine	
99205 GT	Evaluation/Management – Physician/New Patient, Telemedicine	

99212 GT	Evaluation/Management – Physician/Established Patient, Telemedicine	
99213 GT	Evaluation/Management – Physician/Established Patient, Telemedicine	
99214 GT	Evaluation/Management – Physician/Established Patient, Telemedicine	
99215 GT	Evaluation/Management – Physician/Established Patient, Telemedicine	
99202 GT AF	Evaluation/Management – Child Psychiatrist/New Patient, Telemedicine	
99203 GT AF	Evaluation/Management – Child Psychiatrist/New Patient, Telemedicine	
99204 GT AF	Evaluation/Management – Child Psychiatrist/New Patient, Telemedicine	
99205 GT AF	Evaluation/Management – Child Psychiatrist/New Patient, Telemedicine	
99212 GT AF	Evaluation/Management – Child Psychiatrist/Established Patient, Telemedicine	
99213 GT AF	Evaluation/Management – Child Psychiatrist/Established Patient, Telemedicine	
99214 GT AF	Evaluation/Management – Child Psychiatrist/Established Patient, Telemedicine	
99215 GT AF	Evaluation/Management – Child Psychiatrist/Established Patient, Telemedicine	
99212 HE	Evaluation/Management – Psychiatric Pharmacist/Established Patient	
99213 HE	Evaluation/Management – Psychiatric Pharmacist/Established Patient	
99214 HE	Evaluation/Management – Psychiatric Pharmacist/Established Patient	
99215 HE	Evaluation/Management – Psychiatric Pharmacist/Established Patient	
99202 HK	Evaluation/Management – Physician/New Patient (ACT)	
99203 HK	Evaluation/Management – Physician/New Patient (ACT)	
99204 HK	Evaluation/Management – Physician/New Patient (ACT)	
99205 HK	Evaluation/Management – Physician/New Patient (ACT)	
99212 HK	Evaluation/Management – Physician/Established Patient (ACT)	
99213 HK	Evaluation/Management – Physician/Established Patient (ACT)	

99214 HK	Evaluation/Management – Physician/Established Patient (ACT)	
99215 HK	Evaluation/Management – Physician/Established Patient (ACT)	
99202 HK AR	Evaluation/Management-Physician Assistant/New Patient (ACT)	
99203 HK AR	Evaluation/Management-Physician Assistant/New Patient (ACT)	
99204 HK AR	Evaluation/Management-Physician Assistant/New Patient (ACT)	
99205 HK AR	Evaluation/Management-Physician Assistant/New Patient (ACT)	
99212 HK AR	Evaluation/Management-Physician Assistant/Established Patient (ACT)	
99213 HK AR	Evaluation/Management-Physician Assistant/Established Patient (ACT)	
99214 HK AR	Evaluation/Management-Physician Assistant/Established Patient (ACT)	
99215 HK AR	Evaluation/Management-Physician Assistant/Established Patient (ACT)	
99202 HK GC	Evaluation/Management - Psychiatric Resident/New Patient (ACT)	
99203 HK GC	Evaluation/Management - Psychiatric Resident/New Patient (ACT)	
99204 HK GC	Evaluation/Management - Psychiatric Resident/New Patient (ACT)	
99205 HK GC	Evaluation/Management - Psychiatric Resident/New Patient (ACT)	
99212 HK GC	Evaluation/Management - Psychiatric Resident/Established Patient (ACT)	
99213 HK GC	Evaluation/Management - Psychiatric Resident/Established Patient (ACT)	
99214 HK GC	Evaluation/Management - Psychiatric Resident/Established Patient (ACT)	
99215 HK GC	Evaluation/Management - Psychiatric Resident/Established Patient (ACT)	
99212 HK HE	Evaluation/Management – Psychiatric Pharmacist/Established Patient (ACT)	
99213 HK HE	Evaluation/Management – Psychiatric Pharmacist/Established Patient (ACT)	
99214 HK HE	Evaluation/Management – Psychiatric Pharmacist/Established Patient (ACT)	
99215 HK HE	Evaluation/Management – Psychiatric Pharmacist/Established Patient (ACT)	

99202 SA	Evaluation/Management – APN/New Patient	
99203 SA	Evaluation/Management – APN/New Patient	
99204 SA	Evaluation/Management – APN/New Patient	
99205 SA	Evaluation/Management – APN/New Patient	
99212 SA	Evaluation/Management – APN/Established Patient	
99213 SA	Evaluation/Management – APN/Established Patient	
99214 SA	Evaluation/Management – APN/Established Patient	
99215 SA	Evaluation/Management – APN/Established Patient	
99202 SA GT	Evaluation/Management – APN/New Patient, Telemedicine	
99203 SA GT	Evaluation/Management – APN/New Patient, Telemedicine	
99204 SA GT	Evaluation/Management – APN/New Patient, Telemedicine	
99205 SA GT	Evaluation/Management – APN/New Patient, Telemedicine	
99212 SA GT	Evaluation/Management – APN/Established Patient, Telemedicine	
99213 SA GT	Evaluation/Management – APN/Established Patient, Telemedicine	
99214 SA GT	Evaluation/Management – APN/Established Patient, Telemedicine	
99215 SA GT	Evaluation/Management – APN/Established Patient, Telemedicine	
99202 SA HK	Evaluation/Management – APN/New Patient (ACT)	
99203 SA HK	Evaluation/Management – APN/New Patient (ACT)	
99204 SA HK	Evaluation/Management – APN/New Patient (ACT)	
99205 SA HK	Evaluation/Management – APN/New Patient (ACT)	
99212 SA HK	Evaluation/Management – APN/Established Patient (ACT)	
99213 SA HK	Evaluation/Management – APN/Established Patient (ACT)	
99214 SA HK	Evaluation/Management – APN/Established Patient (ACT)	
99215 SA HK	Evaluation/Management – APN/Established Patient (ACT)	
99341 HK	Evaluation/Management – Physician/New Patient (ACT)	
99341 HK AF	Evaluation/Management – Child Psychiatrist/New Patient (ACT)	
99341 HK AR	Evaluation/Management – Physician Assistant/New Patient (ACT)	
99341 HK GC	Evaluation/Management-Resident/New Patient (ACT)	

99341 SA HK	Evaluation/Management – APN/New Patient (ACT)	
99342 HK	Evaluation/Management – Physician/New Patient (ACT)	
99342 HK AF	Evaluation/Management – Child Psychiatrist/New Patient (ACT)	
99342 HK AR	Evaluation/Management – Physician Assistant/New Patient (ACT)	
99342 HK GC	Evaluation/Management-Resident/New Patient (ACT)	
99342 SA HK	Evaluation/Management – APN/New Patient (ACT)	
99344 HK	Evaluation/Management – Physician/New Patient (ACT)	
99344 HK AF	Evaluation/Management – Child Psychiatrist/New Patient (ACT)	
99344 HK AR	Evaluation/Management – Physician Assistant/New Patient (ACT)	
99344 HK GC	Evaluation/Management-Resident/New Patient (ACT)	
99344 SA HK	Evaluation/Management – APN/New Patient (ACT)	
99345 HK	Evaluation/Management – Physician/New Patient (ACT)	
99345 HK AF	Evaluation/Management – Child Psychiatrist/New Patient (ACT)	
99345 HK AR	Evaluation/Management – Physician Assistant/New Patient (ACT)	
99345 HK GC	Evaluation/Management-Resident/New Patient (ACT)	
99345 SA HK	Evaluation/Management – APN/New Patient (ACT)	
99347 HK	Evaluation/Management – Physician/Established Patient (ACT)	
99347 HK AF	Evaluation/Management – Child Psychiatrist/Established Patient (ACT)	
99347 HK AR	Evaluation/Management – Physician Assistant/New Patient (ACT)	
99347 HK GC	Evaluation/Management-Resident/Established Patient (ACT)	
99347 HK HE	Evaluation/Management – Psychiatric Pharmacist/Established Patient (ACT)	
99347 SA HK	Evaluation/Management – APN/Established Patient (ACT)	
99348 HK	Evaluation/Management – Physician/Established Patient (ACT)	
99348 HK AF	Evaluation/Management – Child Psychiatrist/Established Patient (ACT)	

99348 HK AR	Evaluation/Management – Physician Assistant/New Patient (ACT)	
99348 HK GC	Evaluation/Management-Resident/Established Patient (ACT)	
99348 HK HE	Evaluation/Management – Psychiatric Pharmacist/Established Patient (ACT)	
99348 SA HK	Evaluation/Management – APN/Established Patient (ACT)	
99349 HK	Evaluation/Management – Physician/Established Patient (ACT)	
99349 HK AF	Evaluation/Management – Child Psychiatrist/Established Patient (ACT)	
99349 HK AR	Evaluation/Management – Physician Assistant/New Patient (ACT)	
99349 HK GC	Evaluation/Management-Resident/Established Patient (ACT)	
99349 HK HE	Evaluation/Management – Psychiatric Pharmacist/Established Patient (ACT)	
99349 SA HK	Evaluation/Management – APN/Established Patient (ACT)	
99350 HK	Evaluation/Management – Physician/Established Patient (ACT)	
99350 HK AF	Evaluation/Management – Child Psychiatrist/Established Patient (ACT)	
99350 HK AR	Evaluation/Management – Physician Assistant/New Patient (ACT)	
99350 HK GC	Evaluation/Management-Resident/Established Patient (ACT)	
99350 HK HE	Evaluation/Management – Psychiatric Pharmacist/Established Patient (ACT)	
99350 SA HK	Evaluation/Management – APN/Established Patient (ACT)	

5.2 Place of Service

The place of service code must be one of the following:

02 - Telemedicine

03 - School

11 - Office

12 - Home

15 - Mobile Unit

31– Skilled Nursing Facility

32 - Nursing Facility

56 - Psychiatric Residential Treatment Center

99 - Other Unlisted Facility